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Table of Contents

1 Health Certificate	M-1
Underwritten by Anthem Insurance Companies, Inc.	
2 Dental Certificate	D-1
Underwritten by Anthem Insurance Companies, Inc.	
3 Vision Certificate	V-1
Underwritten by Anthem Insurance Companies, Inc.	
4 Indiana Life and Health Insurance Guaranty Association Disclaimer	M-1
5 HIPAA Notice of Privacy Practices	M-1
Underwritten by Anthem Insurance Companies, Inc.	



Underwritten by Anthem Insurance Companies, Inc.

Your Health Certificate

Health Certificate of Coverage

(herein called the “Certificate”)

Blue Access for Health Savings Accounts

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

1 INTRODUCTION

This Certificate is the legal document explaining your coverage. Please read this Certificate carefully, and refer to it whenever you require medical services.

The Certificate explains many of the rights and obligations between you and Us. It also describes how to get medical care, what health services are covered and not covered, and what portion of the health care costs you will be required to pay. Many of the provisions in this Certificate are interrelated; therefore, reading just one or two sections may not give you an accurate impression of your coverage. You are responsible for knowing the terms of this Certificate.

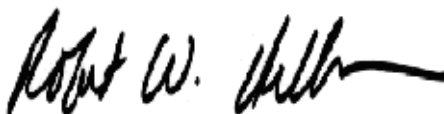
This Health Certificate overrides and replaces any Health Certificate previously issued to you. The coverage described in this Certificate is based upon the conditions of the Group Contract issued to your employer, and is based upon the benefit plan that your Group chose for you. The Group Contract, this Certificate and any endorsements, amendments or riders attached, form the Group Contract under which Covered Services are available under your health care benefits.

Many words used in the Certificate have special meanings. These words are capitalized. If the word or phrase was not explained in the text where it appears, it may be defined in the "Definitions" section. Refer to these definitions for the best understanding of what is being stated.

If you have any questions about this Certificate, please call the member service number located on the back of your Identification (ID) Card or visit www.anthem.com.

How to Obtain Language Assistance

We are committed to communicating with Our Members about their health plan, regardless of their language. We employ a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.



President

2 FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

3 MEMBER RIGHTS AND RESPONSIBILITIES

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

These are your rights and responsibilities:

You have the right to:

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

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose a Network Primary Care Physician (doctor), also called a PCP, if your health care plan requires it.
- Treat all doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors or health care Providers.
- Give Us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our customer service department know if you have any changes to your name, address or family members covered under your Plan.

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

If you need more information or would like to contact Us, please go to [anthem.com](https://www.anthem.com) and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

Contents

1	INTRODUCTION	M-4
2	FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES	M-5
	Choice of Primary Care Physician	M-5
	Access to Obstetrical and Gynecological (ObGyn) Care	M-5
3	MEMBER RIGHTS AND RESPONSIBILITIES	M-6
4	SCHEDULE OF BENEFITS	M-11
5	COVERED SERVICES	M-21
	Ambulance Services	M-22
	Autism Spectrum Disorder Services	M-23
	Behavioral Health Services	M-23
	Clinical Trials	M-24
	Dental Services	M-25
	Diabetic Equipment, Education and Supplies	M-26
	Diagnostic Services	M-26
	Emergency Care and Urgent Care Services	M-28
	Home Care Services	M-29
	Hospice Services	M-30
	Inpatient Services	M-31
	Maternity Services	M-32
	Medical Supplies, Durable Medical Equipment, and Appliances	M-34
	Outpatient Services	M-38
	Physician Home Visits and Office Services	M-39
	Preventive Care Services	M-39
	Surgical Services	M-41
	Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	M-42
	Therapy Services	M-42
	Vision Services	M-45
	Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	M-45
	Prescription Drug Benefits	M-47
6	NON COVERED SERVICES/EXCLUSIONS	M-52
7	ELIGIBILITY AND ENROLLMENT	M-60
	Eligibility	M-60
	College Student Medical Leave	M-61
	Out of Service Area Dependent Child Coverage	M-61
	Enrollment	M-61
	Effective Date of Coverage	M-65
	Statements and Forms	M-65
	Delivery of Documents	M-65
8	Termination	M-65
	Removal of Members	M-66
	Reinstatement	M-66
	Continuation	M-67
	Conversion	M-71
	Family and Medical Leave Act of 1993	M-71

9	HOW TO OBTAIN COVERED SERVICES	M-71
	Network Services and Benefits	M-71
	Non-Network Services	M-73
	Relationship of Parties (Plan - Network Providers)	M-73
	Not Liable for Provider Acts or Omissions	M-74
	Identification Card	M-74
10	CLAIMS PAYMENT	M-74
	How Benefits Are Paid	M-74
	Claims Review	M-78
	Payment of Benefits	M-78
	Services Performed During Same Session	M-78
	Assignment	M-78
	Notice of Claim	M-79
	Time Benefits Payable	M-79
	Claim Forms	M-79
	Member's Cooperation	M-80
	Explanation of Benefits (EOB)	M-80
	Inter-Plan Programs	M-80
11	HEALTH CARE MANAGEMENT	M-83
	Types of Requests:	M-83
	Request Categories:	M-85
	Decision and Notification Requirements	M-85
	HEALTH PLAN INDIVIDUAL CASE MANAGEMENT	M-86
	Voluntary Wellness Incentive Programs	M-87
	Voluntary Clinical Quality Programs	M-87
	Value-Added Programs	M-88
12	MEMBER GRIEVANCES	M-88
	Grievances	M-88
	Appeals	M-89
	Expedited Review	M-89
	External Grievance	M-90
	Grievance/Appeal Filing Time Limit	M-90
	Grievances and Appeals by Members of ERISA Plans	M-91
	Notice To Members	M-91
13	GENERAL PROVISIONS	M-91
	Entire Contract	M-91
	Form or Content of Certificate	M-91
	Disagreement with Recommended Treatment	M-92
	Circumstances Beyond the Control of the Plan	M-92
	Coordination Of Benefits	M-92
	Medicare	M-97
	Physical Examination	M-97
	Workers' Compensation	M-97
	Other Government Programs	M-98
	Subrogation and Reimbursement	M-98
	Right of Recovery	M-99

Relationship of Parties (Group-Member Plan)	M-100
Anthem Blue Cross and Blue Shield Note	M-100
Modifications	M-100
Conformity with Law	M-100
Clerical Error	M-101
Policies and Procedures	M-101
Medical Policy and Technology Assessment	M-101
Waiver	M-101
Plan's Sole Discretion	M-101
Reservation of Discretionary Authority	M-102
Legal Action	M-102
14 DEFINITIONS	M-102

4 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copayments, maximums and other limits that apply 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 endorsements, amendments, or riders.

This Schedule of Benefits lists the Member's responsibility for Covered Services.

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use 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 Coinsurance, Copayments, Deductibles, and non-covered charges.

Copayments/Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

Under certain circumstances, if We pay the Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, We may collect such amounts directly from you. You agree that We have the right to collect such amounts from you.

Essential Health Benefits provided within this Certificate are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

BENEFIT PERIOD

Calendar Year

DEPENDENT AGE LIMIT To the end of the month in which the child attains age 26

DEDUCTIBLE

	Network	Non-Network
Per Family	\$6,000	\$12,000

Note: The Network and Non-Network Deductibles are separate and cannot be combined.

Note: All Covered Services are subject to the Deductible except for the following:

- Network Preventive Care Services

The Deductible must be satisfied before Covered Services are paid by the Plan, except for the services listed above.

OUT-OF-POCKET LIMIT

	Network	Non-Network
Per Family	\$12,900	\$25,400

Note: The Out-of-Pocket Limit includes all Deductible and Copayment / Coinsurance amounts you pay, except when paid for the following services:

- Non-Network Human Organ and Tissue Transplant Services

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

Network and Non-Network Deductibles, Copayments, Coinsurance, and Out-of-Pocket Limits are separate and do not accumulate toward each other.

COVERED SERVICES	COPAYMENTS/COINSURANCE/MAXIMUMS	
	Network	Non-Network
Ambulance Services (Air and Water)	20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.

Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through Precertification. Please see "Health Care Management" for details.

Ambulance (Ground)	Services	20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.
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Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see "Health Care Management" for details.

Behavioral Health Services	20% Coinsurance	50% Coinsurance
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Note: Coverage for the treatment of Behavioral Health and Substance Abuse conditions is provided in compliance with state and federal law.

Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia)	Copayments / Coinsurance based on setting where Covered Services are received.	Copayments / Coinsurance based on setting where Covered Services are received.
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Benefit Maximum for Surgical Treatment and anesthesia for Accidental Dental Services

Covered Services are limited to \$3,000 per Member per accident (Network and Non-Network combined).

Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than the Physician performing the service, or to services that We are required by law to cover.

Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received.	Copayments/Coinsurance based on setting where Covered Services are received.
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For information on equipment and supplies, see "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule.

Screenings for gestational diabetes are covered under "Preventive Care."

For information on Prescription Drug coverage, see "Prescription Drugs".

Diagnostic Services	When rendered as Physician Home Visits and Office Services or Outpatient Services the Co-payment/Coinsurance is based on the setting where Covered Services are received except as listed below. If laboratory services are provided by an Outpatient Hospital laboratory which is not part of Our Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit.	Copayments / Coinsurance based on setting where Covered Services are received.
Note: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services are subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.		
Emergency Room Services	20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.
Home Care Services	20% Coinsurance	50% Coinsurance
Maximum Visits per Benefit Period	100 visits, Network and Non-Network combined	
Note: Maximum does not apply to Home Infusion Therapy or Private Duty Nursing rendered in the home.		
Private Duty Nursing Maximum per Member per Benefit Period	82 visits	
Lifetime Maximum	164 visits	
Hospice Services	20% Coinsurance	20% Coinsurance
Inpatient and Outpatient Professional Services	20% Coinsurance	50% Coinsurance

Inpatient Facility Services	20% Coinsurance	50% Coinsurance
Maximum days per Benefit Period for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	60 days, combined Network and Non-Network	
Maximum days per Benefit Period for Skilled Nursing Facility	90 days, combined Network and Non-Network	
Mammograms (Outpatient diagnostic & routine)	Please see the "Preventive Care Services" provision in this Schedule.	
Maternity Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Network Pharmacy.)	20% Coinsurance	50% Coinsurance
<p>Note: Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.</p> <p>Maximum per Benefit Period for Wigs following cancer treatment</p> <p>One wig per Benefit Period Network and Non-Network</p> <p>Note: If durable medical equipment or appliances are obtained through your PCP/SCP or another Network Physician's office, Urgent Care Center Services, Other Outpatient Services, Home Care Services the Copayment/Coinsurance listed above will apply in addition to the Copayment/Coinsurance in the setting where Covered Services are received.</p>		
Outpatient Services		
Outpatient Surgery Hospital/ Alternative Care Facility	20% Coinsurance	50% Coinsurance
Other Outpatient Services	20% Coinsurance	50% Coinsurance

Note: Physical Medicine Therapy obtained through Day Rehabilitation Programs is subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Physician Home Visits and Office Services

Primary Care Physician (PCP)	20% Coinsurance	50% Coinsurance
Specialty Care Physician (SCP)	20% Coinsurance	50% Coinsurance
Online Visits	20% Coinsurance	50% Coinsurance
Allergy Injections	20% Coinsurance	50% Coinsurance

Notes: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations covered under "Preventive Care Services" in the Certificate) received in a Physician's office are subject to the Other Outpatient Services Copayment / Coinsurance.

The allergy injection Copayment/Coinsurance will be applied when the injection(s) is billed by itself. The office visit Copayment/Coinsurance will apply if an office visit is billed with an allergy injection.

Preventive Care Services	No Copayment / Coinsurance up to the Maximum Allowable Amount.	Copayments/Coinsurance based on setting where Covered Services are received
Surgical Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
Therapy Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received

Note: If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.

Maximum Visits per Benefit
Period for:

Physical Therapy	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Occupational Therapy	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Speech Therapy	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Manipulation Therapy	12 visits, combined Network & Non-Network
Cardiac Rehabilitation	36 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Pulmonary Rehabilitation	20 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.

Urgent Care Center Services	20% Coinsurance	50% Coinsurance
Allergy injections	20% Coinsurance	50% Coinsurance

Notes: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs received in an Urgent Care Center are subject to the Other Outpatient Services Copayment / Coinsurance.

The allergy injection Copayment / Coinsurance will be applied when the injection(s) is billed by itself. The Urgent Care Center visit Copayment / Coinsurance will apply if an Urgent Care Center visit is billed with an allergy injection.

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

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

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

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to applicable Member cost shares.

Transplant Benefit Period	Network Provider	Transplant	Non-Network Provider	Transplant
	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Transplant Case Manager for specific Network Transplant Provider information) for services received at or coordinated by a Network Transplant Provider Facility.		Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.	
Deductible	Network Provider Applicable	Transplant	Non-Network Provider Applicable. During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.	Transplant

Covered Transplant Procedure during the Transplant Benefit Period	Network Provider	Transplant	Non-Network Transplant Provider
	<p>During the Transplant Benefit Period, 20% Coinsurance</p> <p>Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.</p>		<p>During the Transplant Benefit Period, You will pay 50% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit.</p> <p>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 the Plan's Maximum Allowable Amount.</p> <p>If the Provider is a Non-Network Provider for this Certificate, you will be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount.</p> <p>Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.</p>
Covered Transplant Procedure during the Transplant Benefit Period	Network Provider Professional and Ancillary Providers	Transplant Professional and Ancillary (non-Hospital) Providers	Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
	20% Coinsurance		<p>You are responsible for 50% of Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.</p>
Transportation and Lodging	Covered, as approved by the Plan, up to a \$10,000 benefit limit per transplant		Not Covered for Transplants received at a Non-Network Transplant Provider Facility

Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure

Covered, as approved by the Plan, up to a \$30,000 per transplant benefit limit.

Covered, as approved by the Plan, up to a \$30,000 per transplant benefit limit. You will be responsible for 50% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.

Live Donor Health Services

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

You will pay 50% of the Maximum Allowable Amount for Medically Necessary live organ donor expenses. These charges will NOT apply to your Out-of-Pocket Limit. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement.

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

Mail Service 90

Retail Specialty Pharmacy (Network & Non-Network) and Specialty Mail Service 30

Network Retail Pharmacy Prescription Drug Copayment / Coinsurance: 20% Coinsurance per Prescription Order

Specialty Network Retail, Including Specialty Mail Service Program, Prescription Drug Copayment / Coinsurance: 20% Coinsurance per Prescription Order

The PBM's Mail Service Program Prescription Drug Copayment/Coinsurance: 20% Coinsurance per Prescription Order

Non-Network Retail Pharmacy and Non-Network Specialty Pharmacy Prescription Drug Copayment: 50% Coinsurance per Prescription Order

Orally Administered Cancer Chemotherapy

Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when obtained from a Network Pharmacy, Mail Service Program, Specialty Pharmacy Network, or Non-Network Pharmacy.

As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.

Note: Certain Diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments/Coinsurance 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. Diabetic test strips are covered subject to applicable Prescription Drug Copayment/Coinsurance.

5 COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **To receive maximum benefits for Covered Services, care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider to be a Covered Service, except for Emergency Care and Urgent Care. Services which are not received from a PCP, SCP or another Network Provider or approved as an Authorized Service will be considered a Non-Network service, except as specified above.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care and Urgent Care.

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 Coinsurance, 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 receipt of care from a PCP, SCP or another Network Provider, 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 and medical policy. 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 Coinsurance, Copayment, Deductible, or Benefit Period Limit/Maximum.**

Ambulance Services

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

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

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

Ambulance services are subject to Medical Necessity reviews by Us. When using an air ambulance, We reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider We select, the Non-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

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

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

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

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

Important Notes on Air Ambulance Benefits

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

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

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

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Certificate in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Plan.

Behavioral Health Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for Inpatient Services, Outpatient Services, and Physician Home Visits & Office Services for the treatment of Behavioral Health conditions is provided in compliance with state and federal law.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

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

You can get Covered Services from the following Providers:

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

Clinical Trials

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

Benefits are limited to the following trials:

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

- ii. The Department of Defense.
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
 3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your plan may require you to use a Network Provider to maximize your benefits.

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

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

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

Dental Services

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

Related to Accidental Injury

Outpatient Services, Physician Home Visits and 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 unless the chewing or biting results from an act of domestic violence or directly from a medical condition. "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.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member who is physically or mentally disabled, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Diabetic Equipment, Education and Supplies

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

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

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- 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.

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

Diagnostic Services

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

Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- 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).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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.

For Diagnostic services other than those approved to be received in a Physician's office, you may be required to use Our independent laboratory Network Provider called the Reference Laboratory Network (RLN).

Emergency Care and Urgent Care Services

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

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. 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 Coinsurance, Copayment or Deductible.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method We generally use to determine payments for Non-Network services but substituting the Network cost-sharing provisions for the Non-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

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 are open to treat an Emergency 24 hours a day, 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 reasonably 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 and Physician services, and supplies and Prescription Drugs charged by that facility.

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 48 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 contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is no longer considered 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 service 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/Coinsurance. Urgent Care services can

be obtained from a Network or Non-Network Provider. However, you must obtain Urgent Care services from a Network Provider to receive maximum benefits. Urgent Care Services received from a Non-Network Provider will be covered as a Non-Network service and you will be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. 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 life threatening 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.

See your Schedule of Benefits for benefit limitations.

Home Care Services

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

Covered Services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services 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. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). 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).
- Private Duty Nursing.

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

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

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.

- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one year after the Member's death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to Us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Certificate.

Inpatient Services

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

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- 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 Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other 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; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Maternity Services

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

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, and ordinary routine nursery care for a healthy newborn.

If the Member is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Network Provider to have Covered Services paid at the Network level. If the Member is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period. The Member must complete a Continuation of Care Request Form and submit to Us.

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 Coinsurance/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 cesarean 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 Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your 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 care visits** at your residence by a Physician or Nurse performed no later than 48 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. assistance and training in breast or bottle feeding; and
3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

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

In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

- Phenylketonuria.
- Hypothyroidism.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:
 1. Tandem mass spectrometry (MS/MS).
 2. High volume radioimmunoassay.
 3. Hemoglobin electrophoresis.
 4. Isoelectric focusing.
 5. Bacterial inhibition assays.

6. Immunoreactive trypsin (IRT).
7. DNA testing.

Abortion Services - Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Medical Supplies, Durable Medical Equipment, and Appliances

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

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 needed 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 which 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.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliance described below.

Covered Services may include, but are not limited to:

- **Medical and surgical supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Anthem's Prescription Drug benefit or if the supplies, equipment or appliances are not received from the PBM's Mail Service or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self administered and are provided in a Physician's office, including but not limited to, Depo-Provera and Remicade. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1. Allergy serum extracts
2. Chem strips, Glucometer, Lancets
3. Clinitest
4. Needles/syringes
5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

Non Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators
2. Arch supports
3. Doughnut cushions
4. Hot packs, ice bags
5. vitamins
6. medijectors

If you have any questions regarding whether a specific medical or surgical supply is covered call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

- **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; 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. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips

3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube
7. Cardiac, neonatal and sleep apnea monitors
8. Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items may include but are not limited to:

1. Air conditioners
2. Ice bags/coldpack pump
3. Raised toilet seats
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, 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.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may 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 sources, 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 four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.

5. 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). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis).
9. Wigs following cancer treatment, limited to the maximum shown in the Schedule of Benefits.

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. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

- **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, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

Covered orthotic devices may 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 shoe.
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.

Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
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.

If you have any questions regarding whether a specific orthotic is covered call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

- **Prosthetic limbs & Orthotic custom fabricated brace or support** - Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1. determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2. not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Outpatient Services

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

Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by Us. 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 received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

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

Physician Home Visits and Office Services

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

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Care", "Maternity Care" and "Home Care Services" for services covered by the Plan. For Emergency 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 allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

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

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

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

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Online visits. When available in your area, your coverage will include online visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Non Covered Services include but are not limited to communications used for:

- Reporting normal lab or other test results
- Office appointment requests
- Billing, insurance coverage or payment questions
- Requests for referrals to doctors outside the online care panel
- Benefit precertification
- Physician to Physician consultation

Preventive Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, or Copayments.

Preventive care services include screenings and other services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

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

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

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force.
Examples of these services are screenings for:
 - a. Breast cancer;
 - b. Cervical cancer;
 - c. Colorectal cancer;
 - d. High Blood Pressure;
 - e. Type 2 Diabetes Mellitus;
 - f. Cholesterol;
 - g. Child and Adult Obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - a. Women’s contraceptives, sterilization procedures, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the Prescription Drug benefit.
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
 - c. Gestational diabetes screening.

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

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Other Covered Services are:

- Routine hearing screenings
- Routine vision screenings

Surgical Services

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

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

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- 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;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered. Covered Services include the following:

- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Services

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

Note: Coverage for reconstructive services does not apply to orthognathic surgery. See the “Surgical Services” section above for that benefit.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, 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
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Sterilization

Sterilization is a Covered Service. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

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

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

They are covered if provided within Our guidelines.

Therapy Services

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

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy 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. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **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). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations 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 Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. 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. As a condition of coverage the Plan will not require you to

receive dialysis treatment at a Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients 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 Inpatient 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.

Non-Covered Services for physical medicine and rehabilitation include, but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Vision Services

Benefits are available for medical and surgical treatment of injuries and/or diseases affecting the eye. Vision screenings required by federal law are covered under the “Preventive Care” benefit. Benefits for other Covered Services are based on the setting in which services are received.

Benefits are not available for glasses and contact lenses except as described in the “Prosthetics” benefit.

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

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

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

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

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

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and transfusions as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

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

Prior Approval and Precertification

In order to maximize your benefits, We strongly encourage you to call Our transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you

have an evaluation and/or work-up for a transplant. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card **and ask for the transplant coordinator**. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

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

Transportation and Lodging

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 and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

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

Non-Covered Services for transportations and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Interim visits to a medical care facility while waiting for the actual transplant procedure,

- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Prescription Drug Benefits

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

Pharmacy Benefits Manager

The pharmacy benefits available to you under this Certificate are managed by Our Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which We contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, a Specialty pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating, the covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies and, operating a Mail Service pharmacy, and a Specialty Drug Pharmacy Network. The PBM, in consultation with Us, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Customer Service telephone number on the back of your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

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 the PBM 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 which the PBM will administer. 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. The PBM uses pre-approved criteria, developed by Our Pharmacy and Therapeutics Committee which is reviewed and adopted by Us. We, or the PBM may contact your Provider if additional information is required to determine whether Prior Authorization should be granted. We communicate the results of the decision to both you and your Provider.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the Member Grievances section of this Certificate.

For a list of the current Drugs requiring Prior Authorization, please contact the Customer Service telephone number on the back of your ID card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a

guarantee of coverage under your Certificate. Refer to the Prescription Drug benefit sections in this Certificate for information on coverage, limitations and exclusions. Your Provider or Network Pharmacist may check with Us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Plan.

Therapeutic Substitution of Drugs is a program approved by Us and managed by the PBM. This is a voluntary program designed to inform Members and Physicians about possible alternatives to certain prescribed Drugs. We, or the PBM, may contact you and your prescribing Physician to make you aware of 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 questions or issues involving therapeutic Drug substitutes, call the Customer Service telephone number on the back of your ID card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

Step Therapy

Step therapy protocol means that a Member may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Specialty Pharmacy Network

The PBM's Specialty Pharmacy Network is available to Members who use Specialty Drugs.

"Specialty Drugs" are Prescription Legend Drugs which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Network Specialty Pharmacies may fill both retail and mail service Specialty Drug Prescription Orders, subject to a day supply limit for Retail and Mail Service, and subject to the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

Network Specialty Pharmacies have dedicated patient care coordinators to help you manage your condition and offer toll-free twenty-four hour access to nurses and registered Pharmacists to answer questions regarding your medications.

You may obtain a list of the Network Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your ID card, or review the lists on Our website at www.anthem.com.

Covered Prescription Drug Benefits

- Prescription Legend Drugs.

- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs, injectable contraceptive drugs and patches are covered when obtained through an eligible Pharmacy. Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for further details.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered subject to the applicable Prescription Drug Copayment/Coinsurance. 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, Equipment and Appliances instead of under Prescription Drug benefits.
- Injectables.
- Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. Benefits include FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These services will be covered under the “Preventive Care” benefit. Please see that section for further details.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

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

- Prescription Drugs dispensed by any Mail Service program other than the PBM’s Mail Service, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This Exclusion does not apply to over-the-counter products that We must cover under federal law with a Prescription.
- Off label use, as approved by Us or the PBM or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.

- Drugs not approved by the FDA.
- 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; they are Covered Services.
- Any Drug which is primarily for weight loss.
- 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 Us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Oral immunizations and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services.
- Drugs in quantities which exceed the limits established by the Plan.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.
- Compound Drugs unless its primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a drug manufacturer.
- Treatment of Onychomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact Us for additional information on these Drugs.
- Refills of lost or stolen medications.

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your scheduled Copayment/Coinsurance amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for any applicable Deductible and Coinsurance/Copayment. If you receive Covered Services from a Non-Network Pharmacy, a Deductible and Coinsurance/Copayment amount may 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. If you are going on vacation and you need more than the days supply allowed for under this Certificate, you should ask your Pharmacist to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

Half-Tablet Program

The Half-Tablet Program will allow Members to pay a reduced Copayment on selected “once daily dosage” medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take “ $\frac{1}{2}$ tablet daily” of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member’s decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact the number on the back of your ID Card.

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, including a Network Specialty Pharmacy, a Non-Network Pharmacy, or the PBM’s Mail Service Program. It is also based upon which Tier We have classified the Prescription Drug or Specialty Drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

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/Coinsurance for which you are responsible.

Your Copayment(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors. For Covered Services provided by a Network or Specialty Drug Network Pharmacy or through the PBM’s Mail Service, you are responsible for all Deductibles and/or Copayment/Coinsurance 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/Coinsurance 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.

Specialty Drugs - You or your Physician can order your Specialty Drugs directly from a Specialty Network Pharmacy, simply call the Customer Service telephone number on the back of your ID card. If

you or your Physician orders your Specialty Drugs from a Specialty Network Pharmacy you will be assigned a patient care coordinator who will work with you and your Physician to obtain Prior Authorization and to coordinate the shipping of your Specialty Drugs directly to you or your Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your Specialty Drug Prescription.

Non-Network Pharmacy – You are responsible for payment of the entire amount charged by the Non-Network Pharmacy, including a Non-Network Specialty Pharmacy. You must submit a Prescription Drug claim form for reimbursement consideration. These forms are available from Us, the PBM, 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 or the PBM. 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 as determined by Anthem or the PBM's normal or average contracted rate with network pharmacies on or near the date of service.

The Mail Service Program – 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, Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill.

6 NON COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary.

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

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 licensed by law to provide Covered Services, as defined in this Certificate. Examples may include masseurs or masseuses (massage therapists) and physical therapist technicians.
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. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
9. For court ordered testing or care unless Medically Necessary.
10. For which you have no legal obligation to pay in the absence of this or like coverage.
11. For the following:
 - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member except as otherwise described in this Certificate.
 - Surcharges for furnishing and/or receiving medical records and reports.
 - Charges for doing research with Providers not directly responsible for your care.
 - Charges that are not documented in Provider records.
 - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
 - For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
12. 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.

13. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
14. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
15. For missed or canceled appointments.
16. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.
17. 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 and D, We will calculate benefits as if they had enrolled.
18. Charges in excess of Our Maximum Allowable Amounts.
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). Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self funded plan prior to coverage under this Certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
22. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
23. For the following:
 - Custodial Care, convalescent care or rest cures.
 - Domiciliary care provided in a residential institution, treatment center, supervised living or halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, halfway house, or outward bound programs, even if psychotherapy is included.
 - Wilderness camps.
24. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
- cleaning and soaking the feet.
 - applying skin creams in order to maintain skin tone.
 - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
25. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
26. For dental treatment, regardless of origin or cause, except as specified elsewhere in this Certificate. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:
- extraction, restoration and replacement of teeth.
 - medical or surgical treatments of dental conditions.
 - services to improve dental clinical outcomes.
27. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
28. For Dental implants.
29. For Dental braces.
30. For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
- transplant preparation.
 - initiation of immunosuppressives.
 - direct treatment of acute traumatic injury, cancer or cleft palate.
31. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
32. Weight loss programs not approved by Us, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
33. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastropasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an

extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Anthem plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post operative time frame.

34. For marital counseling.
35. 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 intraocular surgery, or for soft contact lenses due to a medical condition.
36. For routine vision screenings not required by federal law as described in the "Preventive Care" benefit.
37. For vision orthoptic training.
38. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Certificate.
39. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
40. For services to reverse voluntarily induced sterility.
41. For diagnostic testing or treatment related to infertility.
42. For personal hygiene, environmental control, or convenience items including but not limited to:
 - Air conditioners, humidifiers, air purifiers;
 - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
 - Charges for non-medical self-care except as otherwise stated;
 - Purchase or rental of supplies for common household use, such as water purifiers;
 - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
 - Infant helmets to treat positional plagiocephaly;
 - Safety helmets for Members with neuromuscular diseases; or
 - Sports helmets.
43. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
44. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by Us, or as otherwise described in this Certificate.

45. For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. This includes, but is not limited to suture removal in an emergency room.
46. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.
47. For self-help training and other forms of non-medical self care, except as otherwise provided in this Certificate.
48. For examinations relating to research screenings.
49. For stand-by charges of a Physician.
50. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
51. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
52. For Manipulation Therapy services rendered in the home as part of Home Care Services.
53. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
54. For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.
55. 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 and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergal synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.
56. For any services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
57. For surgical treatment of gynecomastia.
58. For treatment of hyperhidrosis (excessive sweating).
59. For any service for which you are responsible under the terms of this Certificate to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.
60. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by Us through Prior Authorization.

61. Complications directly related to a service or treatment that is a non Covered Service under this Certificate because it was determined by Us to be Experimental/Investigational or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
62. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This Exclusion does not apply to over-the-counter products that We must cover under federal law with a Prescription.
63. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
64. Treatment of telangiectatic dermal veins (spider veins) by any method.
65. Reconstructive services except as specifically stated in the **Covered Services** section of this Certificate, or as required by law.
66. Nutritional and/or dietary supplements, except as provided in this Certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
67. For non-preventive medical nutritional therapy from a Non-Network Provider.
68. For room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission for your condition.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

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 is not covered under the Plan.

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.

7 ELIGIBILITY AND ENROLLMENT

You have coverage provided under this Certificate because of your employment with/membership with/retirement from the Group. You must satisfy certain requirements to participate in the Group's benefit plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by the Group or state and/or federal law and approved by Us.

Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.

Eligibility

The following eligibility rules apply unless you are notified by Us and the Group.

Subscriber

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

- Be either: An employee, Member, or retiree of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and be Actively At Work;
- Meet the eligibility criteria stated in the Group Contract.

Dependents

To be eligible 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 spouse. For information on spousal eligibility please contact the Group.
- The Subscriber's or the Subscriber's spouse's natural children, newborn and legally adopted children, stepchildren, children for whom the Subscriber or the Subscriber's spouse is a legal guardian, or children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.
- The following children, if the Subscriber provides more than fifty percent (50%) of the child's total support: the Subscriber's or the Subscriber's spouse's grandchildren or other blood relatives.

All enrolled eligible, 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 Dependents who cannot work to support themselves due to mental retardation or physical or mental handicap. 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 120 days after the Dependent would

normally become ineligible. You must notify Us if the Dependent's 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.

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

College Student Medical Leave

The Plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). The Plan must receive written certification from the child's Physician confirming the serious illness or injury and the Medical Necessity of the leave or change in status.

Coverage continues even if the plan changes. Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a Plan changes during the extended period of coverage.

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. Benefits are payable at the Network level and are limited to the Maximum Allowable Amount. Payment is subject to any Coinsurance, Copayment and/or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount.

If you are eligible to enroll as a Member, you must enroll at the time agreed upon by the Plan. Otherwise, you may only enroll during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

Enrollment

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Plan. The application must be received by the date stated on the Group Contract or the Plan's underwriting rules for initial application for enrollment. Coverage will be effective based on the waiting period chosen by the Group, and will not exceed 90 days.

If We do not receive the initial application by this date, the Eligible Person can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, which ever 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.

Continuous Coverage

If you were covered by the Group's prior carrier or plan immediately prior to the Group's enrollment with Anthem Blue Cross Blue Shield, with no break in coverage, then you will receive credit for any accrued Deductible and, if applicable and approved by Us, Out of Pocket amounts under that other plan. This does not apply to persons who were not covered by the prior carrier or plan on the day before the Group's coverage with Us began, or to persons who join the Group later.

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 you may receive credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by Us. Any maximums when applicable, will be carried over and charged against the maximums 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, and any maximums will be carried over and charged against maximums.

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 any maximum amounts.

This Section Does Not Apply To You If:

- 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 Us.

Newborn and Adopted Child Coverage

Any Dependent child born while the Subscriber or Member's spouse is eligible for coverage will be covered from birth for a period of 31 days. Any Dependent child adopted while the Subscriber or the Member's spouse is eligible for coverage will be covered from the date of placement for purposes of adoption for a period of 31 days.

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, and will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

To continue coverage beyond the 31 day period after the child's birth or adoption you must notify Us by submitting a Change of Status Form to add the child under the Subscriber's Certificate. The

Change of Status Form must be submitted within 31 days after the birth or placement of the child. If timely notice is given, an additional Premium for the coverage of the newborn child or adopted child will not be charged for the duration of the notice period. However, if timely notice is not given, We may charge an additional Premium from the child's date of birth or placement for adoption. Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure We have accurate records and are able to cover your claims.

Newborn and Adopted Child Coverage will be for illness and injury, including care or treatment of:

- congenital defects;
- birth abnormalities; or
- premature birth.

Adding a Child due to Award of Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship. If We do not receive an application within the 31-day period, the child will be treated as a Late Enrollee.

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 shall provide the benefits of this Certificate in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit 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.

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, if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your other coverage ends (or within 60 days after Medicaid coverage ends) after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). 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, We will not be able to enroll that person until the Group's next Open Enrollment.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, We will not be able to enroll that person until the Group's next Open Enrollment.

Application forms are available from the Plan.

Late Enrollees

You are considered a Late Enrollee if you are an Eligible Person or Dependent who did not request enrollment for coverage:

- During the initial enrollment period; or
- During a 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 you were first entitled to enroll.

However, you will not be enrolled for coverage with the Plan until the next Open Enrollment Period.

Open Enrollment Period

An Eligible Person or Dependent who did not request enrollment for coverage during the initial enrollment period, or during a Special Enrollment period, may apply for coverage at any time, however, will not be enrolled until the Group's next annual enrollment.

Open Enrollment means a period of time (at least 31 days prior to the Group's renewal date and 31 days following) which is held no less frequently than once in any 12 consecutive months.

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 pay for such services. Acceptance of payments from the Group for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 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.

A Member's coverage terminates as specified in the Termination section of this Certificate. 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, sexual orientation or identity, gender or age.

Effective Date of Coverage

For information on your specific Effective Date of Coverage under this Certificate, please see your human resources or benefits department. You can also contact Us by calling the number located on the back of your Identification (ID) Card or by visiting www.anthem.com).

Statements and Forms

Subscribers (or applicants for membership) must complete and submit applications, medical review questionnaires or other forms or statements the Plan may reasonably request.

Applicants for membership understand that all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a Member may result in termination of coverage as provided in the "Changes in Coverage: Termination, Continuation & Conversion" section.

Delivery of Documents

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

8 Termination

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 be effective on your date of termination in which We received 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 will terminate on your date of termination. If you cease to be eligible due to termination of employment, your coverage will terminate on your date of termination. 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 perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying 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.
- A Dependent's coverage will terminate on the date that the person no longer meets the definition of Dependent, except when indicated otherwise in the Schedule of Benefits.
- If coverage is through an association, coverage will 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 terminate on your date of termination, 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 Network 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, effective immediately upon Our written notice to the Group.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan 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 cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

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 the Group's clerical error.

Continuation

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a Group 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 Group's health plan. It can also become available to other Members of your family, who are covered under the Group'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 Group's health plan, you should contact the Group.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Group'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 Group's health plan is lost because of the qualifying event. Under the Group's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Group for Premium payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group'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 Group'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 Group'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 Group's health plan as a "Dependent child."

If Your Group 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 Group, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Group'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 Group's health plan.

When is COBRA Coverage Available

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group 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 the Group will notify the COBRA Administrator (e.g., Human Resources, external vendor) 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 Group within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the Group 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.

How Long Will Continuation Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued only for up to a total of 18 months. In the case of losses of coverage due to the Subscriber's death, divorce or legal separation, the Subscriber's becoming entitled to Medicare benefits or a Dependent child ceasing to be a Dependent under the terms of the Group's health plan, coverage may be continued 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.

How Can You Extend The Length of COBRA Continuation Coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Group of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

- **Disability**

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. You must provide the SSA determination of your disability to the Group within 60 days of receipt. The disability has 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. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Group of that fact within 30 days after SSA's determination.

- **Second Qualifying Event**

An 18-month extension of coverage will be available to spouses and Dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Subscriber, divorce or separation from the covered Subscriber, the covered Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Group's health plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Group within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Trade Act of 1974

Special COBRA rights apply to Subscribers who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their Group health plan coverage ended.

If you, the Subscriber, qualify for assistance under the Trade Act of 1974, you should contact the Group for additional information. You must contact the Group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose these special COBRA rights.

Premiums and the End of COBRA Coverage

Premium will be no more than 102% of the Group rate (unless your coverage continues beyond 18 months because of a disability. In that case, premium in the 19th through 29th months may be 150% of the Group rate).

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Group ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Group would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Other coverage options besides COBRA Continuation Coverage

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

If You Have Questions

Questions concerning your Group's health plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group 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.)

Continuation of Coverage Due To Military Service

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

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

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate 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:

- The 24-month period beginning on the first date of your absence from work; or
- The day after the date on which You fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) 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.

Conversion

Conversion coverage is not available under this Certificate.

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. 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.

9 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 Service from Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care, Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider, or Us to be sure that Prior Authorization and/or precertification has been obtained.

If a Non-Network Provider meets Our enrollment criteria and is willing to meet the terms and conditions for participation, that Provider has the right to become a Network Provider for the product associated with this Certificate.

Network Services and Benefits

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

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the **Member Grievances** section of this Certificate.

- **Network Providers** - include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatrician or other Network Providers as allowed by the Plan. The Primary Care Physician is the Physician who may provide, coordinate, and arrange your health care services. SCP's are Network Physician who provide specialty medical services not normally provided by a PCP. Referrals are never needed to visit a Network Specialist including behavioral health Providers.

To see a doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.
- When you go to the office, be sure to bring your Member Identification Card with you.

For services rendered by Network Providers:

1. 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 Coinsurance, Copayments and/or Deductibles. You may be billed by your Network Provider(s) for any non-Covered Services you receive or when you have not acted in accordance with this Certificate.
2. 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 prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service.

After Hours Care

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

How to Find a Provider in the Network

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

- See the directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your doctor or Provider.

Please note that not all Network Providers offer all services. For example, when you need Outpatient lab services, some Hospital-based labs are not part of Our Reference Lab Network. In those cases you will have to go to a lab in Our Reference Lab Network to get Network benefits. Please call Customer Service before you get services for more information.

If you need help choosing a doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Non-Network Services

Services which are not obtained from a PCP, SCP, or another Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exception is Emergency Care and Urgent Care. In addition, certain services are not covered unless obtained from a Network Provider, see your Schedule of Benefits.

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

- The difference between the actual charge and the Maximum Allowable Amount plus any Deductible and/or Coinsurance/Copayments;
- Services that are not Medically Necessary;
- Non-Covered Services;
- Filing claims; and
- Higher cost sharing amounts.

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 Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

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 the actions of a Provider of health care, services or supplies.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Certificate has the right to services or benefits under this Certificate. If anyone receives services or benefits to which they are not entitled to under the terms of this Certificate, he/she is responsible for the actual cost of the services or benefits.

10 CLAIMS PAYMENT

When you receive care through a Network Provider, you are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim.

A claim must be filed for you to receive Non-Network Services benefits, but many Non-Network Hospitals, Physicians and other Providers will still submit your claim for you. If you submit the claim, use a claim form.

How Benefits Are Paid

Maximum Allowed Amount

General

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Non-Network Providers is based on this/your Certificate's Maximum Allowed Amount for the Covered Service that You receive. Please see the Inter-Plan Programs section for additional information.

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

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under your Certificate and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Certificate.

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

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

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

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or a Non-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this/your Certificate is the rate the Provider has agreed with Us to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or visit www.anthem.com.

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

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

1. An amount based on Our Non-Network Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, We will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Non-Network Provider.

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

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

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

For Prescription Drugs: The Maximum Allowed Amount is the amount determined by Us using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM).

Member Cost Share

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

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Non-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on your benefits when using Non-Network Providers. Please see the Schedule of Benefits in this Certificate for your cost share responsibilities and limitations, or call Customer Service to learn how this Certificate's benefits or cost share amounts may vary by the type of Provider You use.

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

In some instances You may only be asked to pay the lower Network cost sharing amount when You use a Non-Network Provider. For example, if You go to a Network Hospital or Provider facility and

receive Covered Services from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

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

Example: Your plan has a Coinsurance cost share of 20% for Network services, and 30% for Non-Network services after the Network or Non-Network Deductible has been met.

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

- *The Non-Network anesthesiologist's charge for the service is \$1200. The Maximum Allowed Amount for the anesthesiology service is \$950; Your Coinsurance responsibility is 20% of \$950, or \$190 and the remaining allowance from Us is 80% of \$950, or \$760. You may receive a bill from the anesthesiologist for the difference between \$1200 and \$950. Provided the Deductible has been met, your total Out of Pocket responsibility would be \$190 (20% Coinsurance responsibility) plus an additional \$250, for a total of \$440.*
- *You choose a Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; Your Coinsurance responsibility when a Network surgeon is used is 20% of \$1500, or \$300. We allow 80% of \$1500, or \$1200. The Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.*
- *You choose a **NON-NETWORK** surgeon. The Non-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; Your Coinsurance responsibility for the NON-NETWORK surgeon is 30% of \$1500, or \$450 after the NON-NETWORK Deductible has been met. We allow the remaining 70% of \$1500, or \$1050. **In addition**, the Non-Network surgeon could bill You the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of **\$1450**.*

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, We may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Network Provider. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also may authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from a Non-Network Provider and are not able to contact Us until after the Covered Service is rendered. If We authorize a Network cost share amount to apply to a Covered Service received from a Non-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Authorized Services information or to request authorization.

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

Example:

You require the services of a specialty Provider; but there is no Network Provider for that specialty in your state of residence. You contact Us in advance of receiving any Covered Services, and We authorize You to go to an available Non-Network Provider for that Covered Service and We agree that the Network cost share will apply.

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

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

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

Claims Review

We have processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Payment of Benefits

You authorize Us to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), 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 or any applicable state law.

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

Services Performed During Same Session

We may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to Our Maximum Allowable Amount. **If services are performed by Non Network Providers**, then you are responsible for any amounts charged in excess of Our Maximum Allowable Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact Us for more information.

Assignment

The Group cannot legally transfer this Certificate, without obtaining written permission from the Plan. Members cannot legally transfer the coverage. Benefits available under this Certificate are not assignable

by any Member without obtaining written permission from the Plan, unless in a way 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. 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 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. **If We are unable to complete processing of a claim because you or your Provider fail to provide Us with the additional information within 60 days of Our request, the claim will be denied and you will be financially responsible for the claim.**

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 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.

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. 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. 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 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.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either 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 claim 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 Provider'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, Workers' 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.

Explanation of Benefits (EOB)

After you receive medical care, you will 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.

Inter-Plan Programs

Out-of-Area Services

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

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

BlueCard[®] Program

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

Whenever you access covered healthcare services outside Anthem's Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

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

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

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

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

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

Exceptions

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

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card or go to www.anthem.com for more information about such arrangements.

Care Outside the United States – BlueCard® Worldwide

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

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

Call the Service Center in these non-emergency situations:

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

Payment Details

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

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.

- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to Us.

Claim Forms

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

11 HEALTH CARE MANAGEMENT

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to determine when services should be covered by your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

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

If you have any questions regarding the information contained in this section, you may call the Precertification telephone number on the back of your Identification Card or visit www.anthem.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Physician must notify Us within 48 hours of the admission or as soon as possible within a reasonable period of time. 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.

Predetermination – An optional, voluntary Prospective or Concurrent/Continued Stay Review request for a benefit coverage determination for a service or treatment. We will review your Certificate to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Certificate or is Experimental/Investigative as that term is defined in this Certificate.

Post Service Clinical Claims Review – A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Most Network Providers know which services require Precertification and will obtain any required Precertification or request a Predetermination if they feel it is necessary. Your Primary Care Physician and other 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. The ordering Provider, facility or attending Physician will contact Us to request a Precertification or Predetermination 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 request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services provided by a Network Provider	Services provided by a BlueCard/Non-Network/Non-Participating Provider
Provider	<ul style="list-style-type: none"> Member is responsible for Precertification. If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part.
	<ul style="list-style-type: none"> For Emergency admissions you, your authorized representative, or Physician must notify Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will utilize Our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines, and other applicable policies and procedures to assist in making Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically. Your Certificate and Group Contract take precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, contact the Precertification telephone number on the back of your Identification Card.

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

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

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

You may determine whether a Provider is participating in certain programs by contacting customer service number on the back of your ID card.

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

Request Categories:

Urgent – a request for Precertification or Predetermination 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 or subject the Member to severe pain that cannot be adequately managed without such care or treatment.

Prospective – a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.

Concurrent/Continued Stay Review - a request for Precertification or Predetermination that is conducted during the course of Outpatient treatment or during an Inpatient admission.

Retrospective - a request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, We will abide by state regulations. If you reside and/or receive services in a state other than the state where your contract was issued other state-specific Health Care Management requirements may apply. You may call the telephone number on the back of your membership card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non-Urgent	2 business days from the receipt of the request
Concurrent/Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent/Continued Stay Review Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours or 2 business days from the receipt of request whichever is less
Concurrent/Continued Stay Review Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	

Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent/Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent/Continued Stay Review Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent/Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request

If additional information is needed to make Our decision, We will notify the requesting Provider and send written notification to you or your authorized representative of the specific information necessary to complete the review. If We do not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in Our possession.

We will provide notification of Our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- **Verbal:** oral notification given to the requesting Provider via telephone or via electronic means if agreed to by the Provider.
- **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and the Member or authorized Member representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date you receive service:

1. you must be eligible for benefits;
2. premium must be paid for the time period that services are rendered;
3. the service or surgery must be a Covered Service under your Certificate;
4. the service cannot be subject to an exclusion under your Certificate, and
5. you must not have exceeded any applicable limits under your Certificate.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

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

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case

management staff. These Case Management programs are separate from any Covered Services you are receiving.

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

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

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

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under this Certificate, but are separate components of your Group Health Plan which are not guaranteed under your Certificate and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, You may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact Us at the customer service number on your I.D. card and We will work with you (and, if you wish, your doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist You in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) within a specific timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under this Certificate. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, You may receive incentives such as gift cards. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If You receive a gift card and use it for

purposes other than for qualified medical expenses, this may result in taxable income to You. For additional guidance, please consult Your tax advisor.)

Value-Added Programs

We may offer health or fitness related programs to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under your Certificate and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

12 MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on Our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a signed Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance 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, all documents, records, and other information relevant to the Member's appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 5 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our

acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance does not relate to an adverse certification decision (i.e., Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member. Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your 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. You will be given at least 72 hours advance notice of the date and time of the panel meeting, unless your Appeal qualifies for Expedited Review. Appeals concerning adverse certification decisions or the denial of any other prior authorization required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your 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 Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;

- Your Physician believes that the standard appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 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 an 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.

External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
 - an adverse determination of appropriateness; or
 - an adverse determination of Medical Necessity; or
 - a determination that a proposed service is Experimental/Investigational; or
2. Your Appeal is regarding Our decision to rescind coverage under this Certificate; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after You are notified of the Appeal panel's decision concerning your Appeal.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within seventy-two (72) hours if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days after you are notified of Our decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Grievances and 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 Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is 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 an Appeal is pending. You will be notified of your right to file a voluntary Appeal if Our response to your Grievance is adverse. Upon your request, We will also provide you with detailed information concerning an Appeal, including how panelists are selected.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance

Consumer Services Division

311 W. Washington Street, Suite 300,

Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi

13 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. Changes can only be made through a written authorization, signed by an officer of the Plan.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that they, in consultation with their Providers, are responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment recommended by your 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. In this event, the Provider shall have no further responsibility to provide care to you, and We shall have no obligation to have Network Providers available who will render the care.

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 in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, the Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of the Plan, disability affecting a significant number of a Network Provider's staff or similar causes, or health care services provided under this Certificate are delayed or considered impractical. Under such circumstances, the Plan and Network Providers will provide the health care services covered by this Certificate as far as is practical under the circumstances, and according to their best judgment. However, the Plan and Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of the Plan.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Certificate, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Certificate, Plan has the meaning listed in the Definitions section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than Our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar

reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
6. The amount that is subject to the Primary high-deductible health plan's deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
7. Any amounts incurred or claims made under the Prescription Drug program of this Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
 - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by state or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is the higher of the Primary and Secondary Plans’ allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. 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 the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1. We have paid or for whom We have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

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

Medicare

Any benefits covered under both this Certificate and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) 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, if the Member has not enrolled in Medicare Part B, we will calculate benefits as if they had enrolled.

Physical Examination

When a claim is pending, We reserve the right to request a Member to be examined by an applicable Provider. This will be requested as often as reasonably required.

Workers' Compensation

The benefits under this Certificate are not designed to duplicate benefits that Members are eligible for under the Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to a Member shall be paid back by, or on behalf of, the Member to the Plan if the Plan has made or makes payment for the services received. It is understood that coverage under this Certificate does not replace or affect any Workers' Compensation coverage requirements.

Other Government Programs

The benefits under this Certificate shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payor. If the Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, 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 the 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 Plan.
- 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 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:
 1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
 2. 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. The cost share amount shown in your Explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such recovery activity.

We have oversight responsibility for compliance with Provider and 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 responsible for passing information to the Member. For example, if the Plan gives notice to the Group, it is the Group's responsibility to pass that information to the Member. The Group is also responsible for passing eligibility data to the Plan in a timely manner. If the Group does not provide the Plan with timely enrollment and termination information, the Plan is not responsible for the payment of Covered Services for Members.

Anthem Blue Cross and Blue Shield Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate constitutes a contract solely between the Group and Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark 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.

Modifications

This Certificate allows the Group to make 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 permission or involvement of any Member. Changes will not be effective until 30 days after We provide written notice to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Certificate.

Conformity with 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

A clerical error will never disturb or affect a Member's coverage, as long as the Member's coverage is valid under the rules of this Certificate. This rule applies to any clerical error, regardless of whether it was the fault of the Group or the Plan.

Policies and Procedures

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

Under the terms of the Group Contract, the Plan has the authority, in its sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Certificate. The Plan reserves the right to discontinue a pilot or test program at any time. The Plan will provide thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Medical Policy and Technology Assessment

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

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

Waiver

No agent or other person, except an authorized officer of the Plan, has able to disregard any conditions or restrictions contained in this Certificate, to extend the amount of 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, in 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 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 Contract, to determine all questions arising under the Certificate 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 Contract, the Certificate, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

14 DEFINITIONS

If a word or phrase in this Certificate have special meaning, or is a title, it will start with a capital letter. If the word or phrase is not explained in the text where it appears, it will be defined in this section.

If you need additional clarification on any of these definitions, please contact the customer service number located on the back of your ID Card or submit your question online at www.anthem.com.

Actively At Work – An employee who is capable of carrying out their regular job duties and who is present at their place of work. Additionally, Subscribers who are absent from work due to a health related absence or disability and those on maternity leave or scheduled vacation, are considered Actively At Work.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service(s) – A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. 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 Network Coinsurance, Copayment or Deductible. For more information, see the "Claims Payment" section.

Benefit Period – The length of time that We will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends before this length of time, then the Benefit Period also ends.

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

Brand Name Drug – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

Certificate – The document providing a summary of the terms of your benefits. It is attached to, and is a part of, the Group Contract. It is also subject to the terms of the Group Contract.

Copayment – A specific dollar amount of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. The Copayment does not apply to any Deductible that you are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

Coinsurance – A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies after the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions.

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. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission except as otherwise specified in benefits after termination.

Covered Services do not include any services or supplies that are not documented in Provider records.

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.

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. Custodial Care is not specific treatment for an illness or injury. 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
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which you must pay for before We will pay for those Covered Services in each Benefit Period.

Dependent – A Member of the Subscriber's family who is covered under the Certificate, as described in the "Eligibility and Enrollment" Section.

Diagnostic (Service/Testing) – A test or procedure performed on a Member, who is displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for a Member who is not displaying any symptoms. However, this must be ordered by a Provider. Examples of covered Diagnostic Services 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 that a Subscriber's coverage begins under this Certificate. You must be Actively At Work on your Effective Date for your coverage to begin. If you are not Actively At Work on your Effective Date, your Effective Date changes to the date that you do become Actively At Work.

A Dependent's coverage also begins on the Subscriber's Effective Date.

Eligible Person – A person who meets the Group's requirements and is entitled to apply to be a Subscriber.

Emergency (Emergency Medical Condition) – An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and 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 (Emergency Services) - A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient.

Enrollment Date – The day the Group or Member signs up for coverage or, when there is a waiting period, the first day of the waiting period (normally the date that employment begins).

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of certification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-Expedited Review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

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 to be unproven. For how this is determined, see the “Non-Covered Services/Exclusions” section.

External Grievance - Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Certificate.

Family Coverage – Coverage for the Subscriber and all eligible Dependents.

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

Generic Drugs – Prescription Drugs that have been determined by the FDA to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

Grievance - Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or Medically Necessary;

- a determination that a proposed service is Experimental/Investigative;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan or the Group and the Plan;
- Our decision to rescind coverage under this Certificate.

Group – The employer, or other organization, 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 application, any supplemental application or change form, your Identification Card, and any additional legal terms added by Us to the original Contract.

Identification Card / ID Card – A card issued by the Plan, showing the Member's name, membership number, and occasionally coverage information.

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. This does not apply to a Member who is placed under observation for fewer than 24 hours.

Late Enrollee – An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under this Certificate, and who did not qualify for Special Enrollment.

Mail Service – The Anthem Prescription Management 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 Us, and sent directly to your home.

Maximum Allowable Amount (Maximum Allowed Amount) - The maximum amount that We will allow for Covered Services You receive. For more information, see the "Claims Payment" section.

Medically Necessary/ 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 always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;

- 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 or a Covered Service and **does not** guarantee payment.

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 been covered by the required Premium payment; Members are sometimes called “you” or “your” in this Certificate.

Mental Health and Substance Abuse - A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

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

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Provider - A Provider that has been designated as a “center of excellence” by Us and/or a Provider selected to participate as a Network Transplant Provider by a designee. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider 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 Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement nor is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services to you for the Specialty Pharmacy Network.

Non-Network Transplant Provider - Any Provider that has NOT been designated as a “center of excellence” by Us or has not been selected to participate as a Network Transplant Provider by a designee.

Open Enrollment – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; See Eligibility and Enrollment section for more information.

Out of Pocket Limit - A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a Member and/or family, then no additional Deductibles, Coinsurance, and Copayments are required for that person and/or family unless otherwise specified in this Certificate and/or the Schedule of Benefits.

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

Pharmacy and Therapeutics (P&T) Committee – A committee consisting of health care professionals, including Nurses, Pharmacists, and Physicians. The purpose of this committee is to assist in determining clinical appropriateness of Drugs; determining the assignments of Drugs; determining whether a Drug will be included in any of the Formularies; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

Plan (or We, Us, Our) – Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield which provides benefits to Members for the Covered Services described in this Certificate.

Premium – The charges that must be paid by the Subscriber or the Group to maintain coverage. This may be based on your age, depending on the Group’s Contract with the Plan.

Prescription Order – A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

Prescription Legend Drug, Prescription Drug, or Drug – A medicinal substance that is produced to treat illness or injury and is dispensed to Outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, “Caution: Federal law prohibits dispensing without a prescription.” Compounded (combination) medications, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially a copy of the same as an FDA-approved product from a drug manufacturer. Insulin is considered a Prescription Legend Drug under this Certificate.

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

Prior Authorization – The process applied to certain services, supplies, treatment, and certain Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the P&T 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 that deliver Covered Services are described throughout this Certificate. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID card.

- **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:
 1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
 2. Surgery
 3. Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility** - A facility, with an organized staff of Physicians, that:
 1. Is licensed as such, where required;
 2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
 3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
 4. Does not provide Inpatient accommodations; and
 5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Athletic Trainer** – A person licensed under applicable Indiana state law providing physical medicine and rehabilitative services within their scope of practice.
- **Certified Advance Registered Nurse Practitioner**
- **Certified Nurse Midwife**
- **Certified Registered Nurse Anesthetist**
- **Certified Surgical Assistant**
- **Day Hospital** - A facility that provides day rehabilitation services on an Outpatient basis.
- **Dialysis Facility** - A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.
- **Drug Abuse Treatment Facility** - A facility which provides detoxification and/or rehabilitation treatment for drug abuse.
- **Home Health Care Agency** - A facility, licensed in the state in which it is located, which:
 1. Provides skilled nursing and other services on a visiting basis in the Member's home; and

2. 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:

1. Skilled nursing services
2. Prescription Drugs
3. 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 coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.
- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
 1. Provides room and board and nursing care for its patients;
 2. Has a staff with one or more Physicians available at all times;
 3. Provides 24 hour nursing service;
 4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
 5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Treatment of alcohol abuse
8. Treatment of drug abuse

- **Laboratory (Clinical)**

- **Licensed Practical Nurse**

- **Licensed Professional Counselors**

- **Occupational Therapist**

- **Outpatient Psychiatric Facility** - A facility which mainly provides Diagnostic and therapeutic services for the treatment of Behavioral Health Conditions 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** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).
- **Psychiatric Hospital** - A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. 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 First Assistant**
- **Registered Nurse**
- **Registered Nurse Practitioner**
- **Regulated Physician's Assistant**
- **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient 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 (Certified)**
- **Retail Health Clinic** - A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.
- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:
 1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
 2. provides care supervised by a Physician;
 3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
 4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
 5. is not a rest, educational, or custodial Provider or similar place.
- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.

- **Speech Therapist**
- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**
- **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 Plan.

Service Area – The geographical area where Our Covered Services are available.

Single Coverage – Coverage that is limited to the Subscriber only.

Special Enrollment – A period of enrollment in which certain Eligible Persons or their Dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc.

Specialty Care Physician (SCP) - A Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

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; or
- 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 – We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs and Behavioral Health 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 that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed in the "Covered Services" section.



Underwritten by Anthem Insurance Companies, Inc.

Your Dental Certificate

Dental Certificate of Coverage

(herein called the "Certificate")
Anthem Dental Traditional

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

1 CERTIFICATE

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

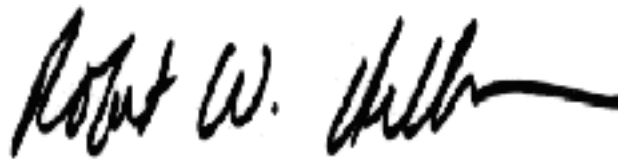
The coverage described in this Certificate is subject in every respect to the provisions of the Group Contract issued to the Group. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services and supplies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

A handwritten signature in black ink, appearing to read "Robert W. Hill", followed by a long horizontal flourish.

President

Contents

1	CERTIFICATE	D-3
2	SCHEDULE OF BENEFITS	D-6
3	DEFINITIONS	D-7
4	ELIGIBILITY AND ENROLLMENT	D-9
	Eligibility	D-9
	Enrollment	D-10
	Special Enrollment/Special Enrollees	D-12
	Effective Date of Coverage	D-13
5	TERMINATION, CONTINUATION AND CONVERSION	D-14
	Reinstatement	D-15
	Conversion	D-15
	Federal Continuation of Coverage (COBRA)	D-15
	Family and Medical Leave Act of 1993	D-17
	Continuation of Coverage Due To Military Service	D-17
	Group Responsible For Notification of Group Cancellation	D-18
	Cessation of Operations	D-18
6	HOW TO OBTAIN COVERED SERVICES	D-18
	Prior Carrier Authorizations for Pre-Existing Dental Conditions	D-18
	Not Liable for Provider Acts or Omissions	D-19
	Identification Card	D-19
7	DENTAL UTILIZATION REVIEW	D-19
	Pre-Treatment Review	D-19
	Retrospective Review	D-19
8	COVERED SERVICES	D-20
	Class I - Preventive Services	D-20
	Diagnostic and Preventive Services	D-20
	Class II A - General Services	D-21
	General (Adjunctive) Services	D-21
	Restorative Services	D-21
	Class II B - Specialty Services	D-22
	Endodontic Services	D-22
	Oral Surgery Services	D-22
	Periodontal Services	D-22
	Class III - Prosthodontic Services	D-23
	Prosthodontic Services	D-23
	Class IV - Orthodontic Services	D-25
	Orthodontic Services	D-25
	Pretreatment Estimates and Treatment Plans	D-25
9	EXCLUSIONS	D-26
10	CLAIMS PAYMENT	D-29
	How to Obtain Benefits	D-29
	Maximum Allowed Amount	D-29
	Payment of Benefits	D-31
	Assignment	D-31

Notice of Claim	D-31
Claim Forms	D-31
Proof of Claim	D-32
Time Benefits Payable	D-32
Member's Cooperation	D-32
Explanation of Benefits	D-32
11 GENERAL PROVISIONS	D-32
Entire Contract	D-32
Form or Content of Certificate	D-33
Disagreement with Recommended Treatment	D-33
Circumstances Beyond the Control of the Plan	D-33
Coordination of Benefits	D-33
Worker's Compensation	D-37
Other Government Programs	D-38
Subrogation/Reimbursement	D-38
Right of Recovery	D-39
Relationship of Parties (Group-Member-Plan)	D-39
Interpretation of Certificate	D-40
Conformity with Law	D-40
Modifications	D-40
Clerical Error	D-40
Medical Examination	D-40
Legal Action	D-40
Policies and Procedures	D-40
Waiver	D-40
Plan's Sole Discretion	D-40
Reservation of Discretionary Authority	D-41
Anthem Insurance Companies, Inc. Note	D-41
12 MEMBER GRIEVANCES	D-41
Grievances	D-41
Appeals	D-42
Grievance/Appeal Filing Time Limit	D-43
Grievances and Appeals by Members of ERISA Plans	D-43
Department of Insurance	D-43

2 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 dental 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. You are responsible for any balance due between the 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 for Dental Services (except Orthodontic Services)	To the end of the month in which the child attains age 26.
Orthodontic Services for Adults	Coverage is not provided for the Subscriber and/or Subscriber's spouse
Dependent Age Limit for Orthodontic Services	To the date the child attains age 19
Dental Deductible	
Per Person	\$25
Per Family	\$75
Note: Any amounts applied to the Deductible for expenses incurred during the last three months of the Benefit Period will be applied to the next Benefit Period's Deductible.	
Annual Maximum per Member	\$1,000
Orthodontic Lifetime Maximum per Member (does not apply to the Annual Maximum)	\$1,000

COVERED SERVICES

COPAYMENTS/MAXIMUMS

Class I - Preventive Services

Diagnostic and Preventive Services
(Not subject to the Deductible)

Covered In Full, up to the Maximum Allowable Amount

The following services are subject to the Deductible:

Class IIA - General Services

General (Adjunctive) Services 20%

Restorative Services 20%

Class IIB - Specialty Services

Endodontic Services	20%
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Oral Surgery Services	20%
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Periodontal Services	20%
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Class III - Prosthodontic Services

Prosthodontic Services	50%
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Class IV - Orthodontic Services

Orthodontic Services	50%
(Not subject to the Deductible)	

3 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.

Alternate Recipient - Any child of a Subscriber who is recognized under a Qualified Medical Child Support Order (QMSCO) as having a right to enrollment under the Group Contract with regard to such Subscriber.

Annual Maximum - The maximum dollar amount payable for Covered Services for each Member during a Benefit Period. The Benefit Period is listed in the Schedule of Benefits. The amounts applied to the Annual Maximum are based on the Maximum Allowable Amount for Covered Services. The annual benefit limit includes both Network and Non-Network services, but does not include the Member's Deductible or Copayment amounts. If your benefit plan covers Orthodontics, benefits for orthodontic services are not included in the Annual Maximum, but are subject to a separate lifetime maximum. Refer to

the Schedule of Benefits for any Annual Maximums or Lifetime Maximum amounts.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Appliance - A device used to provide a function or a therapeutic effect (example: a denture).

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.

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 percentage of the Maximum Allowable Amount for Covered Services indicated in the Schedule of Benefits for which you are responsible.

Covered Services - Services, supplies or treatment as described in the Certificate which are performed, prescribed, directed or authorized by a

Provider. To be considered Covered Services, services must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Certificate is in force;
- Within the Maximum Allowable Amount;
- Not specifically excluded or limited by the Certificate; and
- Specifically included as a benefit within the Certificate.

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.

Effective Date - The date when a Subscriber's coverage begins under this Certificate. You must be Actively at Work on your Effective Date. If you are not 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.

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).

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Grievance - Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- the availability of Providers;
- the handling or payment of claims for dental care services;
- matters pertaining to the contractual relationship between you and the Plan or the Group and the Plan.

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.

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.

Maximum Allowable Amount (Maximum Allowed Amount) - The maximum amount that We will allow for Covered Services You receive. For more information, see the "Claims Payment" section.

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".

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

Plan (We, Us, Our) - Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Certificate.

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

Pretreatment Estimate - A Pretreatment Estimate identifies the Plan's estimated financial liability before treatment is started. This estimate may include some or all of the following information:

- Patient's eligibility
- Covered Services
- Benefit amounts payable
- Deductible amounts, if applicable
- Copayments
- Maximum benefit limitations

Such estimates are subject to the terms of the Member's coverage.

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.

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 Plan.

Single Coverage - Coverage for the Subscriber only.

Subcontractor - Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. 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.

Treatment Plan - A detailed description, submitted by the Provider, outlining the proposed services and fees including any appropriate radiographs and diagnostic information when a Pretreatment Estimate is requested.

4 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 dental 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 Resources 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

- The Subscriber's legal spouse.
- The Subscriber's or the Subscriber's spouse's natural children, newborn and legally adopted children, stepchildren, children for whom the Subscriber or the Subscriber's spouse is a legal guardian, or children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.
- The following children, if the Subscriber provides more than fifty percent (50%) of the child's total support: the Subscriber's or the Subscriber's spouse's grandchildren or other blood relatives.

All enrolled eligible, 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 Dependents who cannot work to support themselves due to mental retardation or physical or mental handicap. 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 120 days after the Dependent would normally become ineligible. You must notify Us if the Dependent's 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 verifying application for 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 with the Plan unless required by the laws of this state.

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

College Student Medical Leave

The Plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). The Plan must receive written certification from the child's Physician confirming the serious illness or injury and the Medical Necessity of the leave or change in status.

Enrollment

Persons who are eligible to enroll as Members must enroll at the time agreed upon by the Plan. Otherwise, they may only enroll during the Open Enrollment period or during a Special Enrollment period, 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 during the open enrollment period or during a special enrollment period, which ever is applicable. An Eligible Person may be subject to a waiting period before coverage becomes effective. The waiting period (if applicable) is listed in the Schedule of Benefits.

If a Dependent of the Eligible Person qualifies as a Dependent with the Plan at the time of the Eligible Person's initial application for enrollment, but does not enroll in this dental Plan, that person can only enroll for coverage during the open enrollment period or during a special enrollment period, which ever 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.

Newly Eligible Persons

Any person who becomes newly eligible after the initial Enrollment period (e.g., new spouse, newly hired or newly transferred Subscriber), is eligible for coverage effective on the first date eligible only if all of the following conditions are met:

- The enrollment form must be received by the Plan within thirty-one (31) days of becoming eligible; and
- Timely payment of the applicable enrollment fees.

This section does not apply to newborn and adopted children. See the Newborn and Adopted Child Coverage provision.

Qualified Medical Child Support Order/Court Ordered Health Coverage

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 shall provide the benefits of this Certificate in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit 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.

Newborn and Adopted Child Coverage

Any Dependent child born while the Subscriber or Subscriber's spouse is eligible for coverage will be covered from birth for a period of 31 days. Any Dependent child adopted while the Subscriber or the Subscriber's spouse is eligible for coverage will be covered from the date of placement for purposes of adoption for a period of 31 days.

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, and will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

To continue coverage beyond the 31 day period after the child's birth or adoption you must notify Us by submitting a Change of Status Form to add the child under the Subscriber's Certificate. The Change of Status Form must be submitted within 31 days after the birth or placement of the child. If timely notice is given, an additional Premium for the coverage of the newborn child or adopted child will not be charged for the duration of the notice period. However, if timely notice is

not given, We may charge an additional Premium from the child's date of birth or placement for adoption.

If the child is not enrolled within 31 days of the date of birth or placement for adoption, coverage will cease.

Newborn and adopted children are exempt from the Pre-Existing exclusion in this Certificate if they are covered under the Plan within thirty-one (31) days of the date of birth or placement for adoption.

Adding a Child due to Award of Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or 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 awards legal custody or guardianship if We receive an application within 31 days of that qualifying event.

Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other dental 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.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, that person is only eligible for coverage as a Late Enrollee.

Application forms are available from the Plan.

Late Enrollment

An eligible Subscriber or Dependent who did not request enrollment for coverage with the Plan during the initial enrollment period, as a newly eligible person, or a special enrollment period during which the individual was entitled to enroll is considered a Late Enrollee and may apply for coverage at any time although will not be enrolled for coverage with the Plan until the next Open Enrollment Period.

Open Enrollment

An Eligible Person or Dependent who did not request enrollment for coverage during the initial enrollment period, or during a Special Enrollment period, may apply for coverage at any time, however, will not be enrolled until the Group's next annual enrollment.

Open Enrollment means a period of time (at least 31 days prior the Group's renewal date and 31 days following) which is held no less frequently than once in any 12 consecutive months.

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 dental plan. 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 dental status, dental care

needs, genetic information, previous medical information, gender, race, 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.

Statements and Forms

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

Delivery of Documents

We will provide the Group with a Plan Identification Card for each Member and a Certificate for each Subscriber.

Notice of Ineligibility

You must notify Us of any changes which will affect your Dependent's eligibility for services or benefits under this Certificate.

5 TERMINATION, CONTINUATION AND CONVERSION

This Certificate of Coverage is issued under a Group Contract. 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 dental coverage. However, the dental 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 be effective on the date 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 date of termination. 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 the date of termination. 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 the date of termination 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 dental 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 on the date of termination 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 Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowable Amount for services received through such misuse.

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.

Conversion

Conversion coverage is not available under this Certificate.

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a Group 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 Group's health plan. It can also become available to other Members of your family, who are covered under the Group'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 Group's health plan, you should contact the Group.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Group'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 Group's health plan is lost because of the qualifying event. Under the Group's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Group for Premium payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group'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 Group'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 Group'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 Group's health plan as a "Dependent child."

If Your Group 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 Group, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Group'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 Group's health plan.

When is COBRA Coverage Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the Group 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 Group 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 Group within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the Group 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 Group's health plan is determined by the Social

Security Administration to be disabled and you notify the Group 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 Group. 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 Group's health plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Group's health plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group 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

A conversion option is not available with this program.

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.

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 coverage for yourself and your Dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

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

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate by notifying your employer in advance and payment of any required contribution for this coverage. This may include the amount the

employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active employee contribution, if any, for continuation of coverage.

If continuation is elected under this provision, the maximum period of coverage under this Certificate shall be the lesser of:

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

Regardless whether you continue your coverage, if you return to your position of employment your 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.

Group Responsible For Notification of Group Cancellation

Upon receipt of notice of cancellation of the coverage under this Certificate, the Group is required contractually to notify you.

Cessation of Operations

In the event of the cessation of operations or dissolution of the Plan, this Certificate may be terminated immediately by Us. The Plan will be obligated for services for the remainder of the period in which Premiums were prepaid or as otherwise prescribed by law.

6 HOW TO OBTAIN COVERED SERVICES

Benefits are provided when you obtain Covered Services from Providers. Benefits for Covered Services are based on the Maximum Allowable Amount. You may be responsible for any balance due between the Provider's charge and the Maximum Allowable Amount in addition to any Copayments, Deductibles, and non-covered charges.

We have final authority to determine whether the service is a Covered Service. We will determine the benefits available according to the terms and provisions of this Certificate. We may inform you that a service you received is not covered under the Certificate. You may appeal this decision. See the **Member Grievances** section of your Certificate.

Prior Carrier Authorizations for Pre-Existing Dental Conditions

If a Member who was previously covered under another dental plan received a Pretreatment Estimate, benefit authorization, or prior approval from the prior carrier, such authorizations will **not** be honored by the Plan. In these cases, to receive a Pretreatment Estimate, the Member should request that the Provider submit a Treatment Plan to Us **before** services are received or completed (if the Member began treatment before changing to coverage under this Certificate). Incomplete services that were begun before the Member's Effective Date that would otherwise be eligible for benefits may not be covered under this Certificate. The Member should request that the Provider submit a Treatment Plan before the incomplete services are received or completed.

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 of dental care, services or supplies, does or does not do.

Identification Card

When you receive care from a Provider, you must show your Identification Card. Possession of an Identification Card confers no right to services or 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.

7 DENTAL UTILIZATION REVIEW

Dental utilization review is a process designed to promote the delivery of cost-effective dental care by encouraging the use of clinically recognized and proven procedures. Dental utilization review is included in your dental benefits to encourage you to utilize your dental benefits in a cost-effective and clinically recognized manner. 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 coverage guidelines, dental policy and utilization review features.

Dental utilization review is accomplished through pre-treatment review and retrospective review. Our dental coverage guidelines for pre-treatment review and retrospective review are intended to reflect the standards of care for dental practice and state-specific regulations. The purpose of dental coverage guidelines is to assist in the interpretation of Medical Necessity. In order to be Covered Services under this Certificate, services must meet the Medically Necessary requirements.

Pre-Treatment Review

You may have a pre-treatment review done before you receive benefits. Pre-treatment review is not a prior authorization for services but is a system that allows you and your Dentist to know, in

advance, what the estimated benefits payable would be under this Certificate for a proposed course of treatment. The actual benefits you receive under the plan will be determined once a claim for services has been received and may vary from the estimated benefits based upon the actual services received as well as the benefit coverage in effect on the date(s) of services.

Under pre-treatment review, your Dentist prepares a request for a pre-treatment benefit estimation form, and submits this form to Us before any treatment begins. The pre-treatment benefit estimation form should: (a) list the recommended dental services; and (b) show the charge for each dental service. We will review this request and send a copy of Our estimated benefits to you and your Dentist. We may request supporting pre-operative x-rays or other diagnostic records in connection with the pre-treatment review. A pre-treatment review is recommended if the proposed course of treatment is expected to involve charges of **\$350 or more**.

If the course of treatment is not reviewed before treatment is received, it will be reviewed when the claim is submitted to Us for payment.

Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after dental care services

have been provided. A claim review includes, but is not limited to, an evaluation of reimbursement levels, accuracy of documentation, accuracy of coding and adjudication of payment.

We provide a toll-free telephone number available during normal business hours to assist you or your Dentist in obtaining information with respect to Our utilization review process. This same number may be utilized after business hours to leave a message which will be responded to within two business days in non-emergency situations.

If a Member disagrees with a utilization review decision and wishes to file a Grievance, or appeal a decision previously made you will find details on how to do this in the Grievance and Appeals section of this Certificate. You may also contact Our customer service number on your ID card.

The utilization review process is governed by laws and regulations, and may be modified from time to time by Us as those laws and regulations may require.

8 COVERED SERVICES

This section describes the Covered Services available under your dental care benefits when provided and billed by eligible Providers. All Covered Services are subject to the exclusions listed in the Exclusions section.

Benefits are limited to Covered Services stated in this Certificate for dental disease, prevention, diagnosis and treatment. Coverage is subject to all the terms and limitations stated in this Certificate, including special treatment schedules and benefit maximums.

If the Member and dentist decide on a personalized restoration as opposed to a standard technique, benefit payment will be based on the Plan's Maximum Allowable Amount for the standard technique. The Member is solely responsible for the balance of charges.

The Maximum Allowable Amount for all Covered Services includes the administration of any local anesthesia and the provision of infection control procedures as required by state and federal mandates. If billed separately, such charges will be denied.

Class I - Preventive Services

Diagnostic and Preventive Services

Diagnostic and preventive services are services that are used to avert dental disease or to

determine the nature or cause of a dental disease. Covered Services include examinations, oral evaluations, x-rays, teeth cleaning and scaling, fluoride treatments, sealants, and selected space maintainers, as listed below.

Oral Evaluation

Limited to two per Benefit Period in any combination of the following types of evaluations: periodic, limited (emergency), comprehensive, detailed, and extensive.

Dental Radiographs (X-rays)

- **Bitewing** radiographs (up to four), limited to once per Benefit Period.
- **Complete series** (panoramic film or full-mouth radiographs), limited to once every three-year period. Complete series radiographs include bitewings, and will count as one occurrence for that Benefit Period. Nine or more radiographs in any combination of periapical and bitewing radiographs will be considered a complete series.

Note: Benefits are not provided for periapical x-rays when performed on the same date as a complete series or a panoramic film.

Radiographs may be allowed more frequently if requested by the Plan for diagnostic evaluation. The Plan reserves the right to request radiographs and/or diagnostic data from the Provider of service.

Cleaning, Scaling, and Polishing the Teeth (Prophylaxis)

Limited to two per Benefit Period, which can vary in degree of difficulty (see "Periodontal Services" for limitations on periodontal scalings and periodontal maintenance procedures).

Space Maintainers

When used to maintain the space for prematurely lost teeth and only when necessary to prevent future orthodontic care. This benefit is provided only once per lifetime and is not available after the Member's 12th birthday. Space maintainers will be recemented only once per lifetime per Appliance.

Other Diagnostic and Preventive Services

Dependent children under the age of 16 are eligible to receive benefits for the following diagnostic and preventive services (benefits are not available after the Dependent reaches age 16):

- **Fluoride treatments** (topical application), limited to two per Benefit Period.
- **Sealants**, but only to the unrestored occlusal surface of permanent, posterior teeth, limited to one per Benefit Period and a lifetime maximum of two applications per tooth.

Class II A - General Services

General (Adjunctive) Services

Covered Services include limited emergency care, office visits, consultations, and anesthesia services, as listed below.

- **Palliative (Emergency) Treatment for Dental Pain**, limited to two treatments per Benefit Period.
- **Consultations**, limited to a lifetime maximum of once per Provider.
- **General anesthesia**, when administered by a qualified, licensed professional.
- **Intravenous sedation**, when administered by a qualified, licensed professional.
- **Office visit for observation**, limited to two visits per Benefit Period (not covered when associated with other services or procedures).

Restorative Services

The process of replacing, by artificial means, a part of a tooth that has been damaged by disease (e.g., cavities). Covered Services include "filling" anterior and posterior teeth and preparing teeth for fillings, as listed below. For services to replace a missing tooth or restore a tooth using a crown, see Prosthodontic Services. Restorative services must not be solely for replacement of existing restorations.

The following are covered restorative services under this Certificate:

- **Amalgam restorations**, limited to once per surface per tooth in any Benefit Period.
- **Composite restorations**, limited to once per surface per tooth in any Benefit Period.
- **Pin retention**, limited to once per tooth in any Benefit Period (regardless of the number of pins per tooth). Pin retention must be performed on the same date of service and in conjunction with a covered amalgam or composite restoration.

Class II B - Specialty Services

Endodontic Services

Dental services for the prevention, diagnosis, and treatment of diseases and injuries affecting the dental pulp, tooth root, and periradicular tissue. Covered Services include root canal fillings (filling the roots of teeth) and limited associated services, as listed below.

Root Canal Therapy

Coverage for root canal therapy includes a Treatment Plan, clinical procedures, postoperative radiographs, and follow-up care (all are included in the total root canal therapy allowance), limited to once per tooth in any three years and to permanent teeth only. Retreatment of root canal therapy is covered.

Other Endodontic Services

The following Covered Services are limited to a lifetime maximum of once per tooth/root:

- **Apexification/recalcification**
- **Apicoectomy/periradicular services** - the Maximum Allowable Amount for apicoectomy/periradicular services includes reimbursement for the removal of granulation tissue at the apex of the tooth. No additional benefit is available if the removal of granulation tissue at the apex of the tooth is billed separately from the apicoectomy/periradicular service.
- **Retrograde filling**
- **Root amputation/hemisection**
- **(Therapeutic pulpotomy excluding final restoration)**, limited to primary teeth only.

Oral Surgery Services

Treatment of certain dental conditions by operative or cutting procedures. Covered Services include tooth extractions, such as a single tooth or third molars (wisdom teeth), and other limited surgical procedures, as listed below. For surgical procedures related to the gums and to the bone that supports teeth, see "**Periodontal Services.**" For root canal procedures, see "**Endodontic Services.**"

- **Simple tooth extractions**
- **Surgical tooth extractions**
- **Alveoloplasty**
- **Vestibuloplasty**
- **Surgical Biopsy**
- **Excision of soft tissue lesions**
- **Excision of intra-osseous lesions**
- **Excision of bone tissue**
- **Frenulectomy**
- **Excision of hyperplastic tissue**
- **Surgical incision and drainage.**

Periodontal Services

Dental services that treat diseases of the tissues that surround and support the teeth (e.g., the gums and the supporting bone). Covered Services include maintenance of the gum tissues and bone that supports the teeth, as listed below.

Periodontal Surgical Services

Coverage for periodontal surgical services includes routine postoperative care, limited to one surgical procedure per quadrant per Member in any three years.

Covered periodontal surgical services are:

- **Gingivectomy or gingivoplasty**, except when performed in conjunction with a crown build-up, post and core, or with a crown (the gingivectomy or gingivoplasty is considered part of that procedure and there will be no additional benefit).
 - **Gingival flap procedure** (includes root planing)
 - **Crown lengthening**, limited to once per tooth per lifetime.
 - **Osseous surgery**, including flap entry with closure, limited to one osseous surgery per quadrant per Member in any three years. Benefits are available for a particular quadrant only for treated teeth having 5-mm pockets or more.
 - **Osseous grafts** are a Covered Service for replacement of bone loss due to periodontal disease.
 - **Soft tissue grafts** - The Maximum Allowable Amount for a soft tissue graft includes removal of tissue from a donor site and a single graft for one tooth or a single graft covering two adjacent teeth. No additional benefit is available when removal of the donor tissue is billed separately from the soft tissue graft or a single graft for two adjacent teeth are billed separately.
 - **Distal or proximal wedge procedure** is a Covered Service only when a periodontal pocket exists and the periodontal pocket measures 5mm or more. No additional benefit for the distal or proximal wedge procedure is available when periodontal surgery is performed in the same anatomical site and the distal or proximal wedge is billed separately.
- supragingival plaque and calculus), limited to a lifetime maximum of once per Member.
- **Periodontal scaling and root planing** are limited to once per quadrant in any two Benefit Periods.
 - **Periodontal maintenance procedures** are limited to two cleanings per Benefit Period, whether routine or for periodontal maintenance.
 - **Occlusal adjustment** (complete or limited) **and Occlusal guards**, performed with osseous surgery or following osseous surgery, limited to lifetime maximum of once per Member.
 - **Provisional splinting** (intracoronary or extracoronary), performed with osseous surgery or following osseous surgery, limited to lifetime maximum of once per Member.

Class III - Prosthodontic Services

Prosthodontic Services

Dental services that restore and maintain the oral function, comfort, and health of a patient by replacing missing teeth and surrounding tissue with artificial substitutes. Covered Services include crowns, bridges, partial dentures, complete dentures, and some services needed to support them, as listed below.

Bridge

A prosthetic dental Appliance that replaces lost teeth, being supported and held in position by attachments to adjacent teeth.

Implant

A device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental placement; endosteal (endosseous); eposteal (subperiosteal); or transosteal (transosseous).

Other (Adjunctive) Periodontal Services

Covered adjunctive periodontal services are:

- **Full-mouth debridement** to enable comprehensive periodontal evaluation and diagnosis (removal of subgingival and/or

Crown

A restoration that reproduces the entire surface anatomy of the clinical crown of a tooth.

Denture

An artificial or prosthetic replacement for missing natural teeth and adjacent tissues.

Crowns/Onlays

Benefits for crowns/onlays, including benefits for the replacement of a lost or defective crown, are limited to once per tooth in any five years (whether placement was under this Certificate or under any prior dental coverage, and even if the original crown was stainless steel or "temporary").

Other Covered Services related to crowns/onlays are:

- **Recementing of crowns/onlays**, limited to a lifetime maximum of once per crown/onlay.
- **Crown buildups** (includes pin retention), limited to once per tooth in any five benefit years (whether placement was under this product or under a prior dental coverage). Amalgam and/or composite restorations submitted in conjunction with crown buildups or post and core procedures will be considered as part of those procedures. Crown buildups performed in conjunction with post and core procedures will be considered part of those procedures. Crown buildups on the same tooth as an amalgam or composite restoration done within the same Benefit Period will **not** be covered.
- **Post and core buildups**, limited to once per tooth in any five years.
- **Crown/onlay repairs**, limited to lifetime maximum of once per crown/onlay.
- **Crown/onlay replacements**, limited to once per tooth in any five years.

- **Stainless steel crowns (for primary teeth only)** Benefits are not provided for stainless steel crowns when used as a temporary crown.

Prosthodontics, Fixed

Fixed bridges are covered only when:

- The bridge is replacing functional teeth; and
- The total units required to replace all missing teeth is six units or less in an arch (arch means maxilla or mandible); and
- The bridge or bridges consist of no more than 6 units total in an arch. (Each abutment is a unit and each pontic is a unit in a bridge).

Note: Benefits are provided for the replacement of an existing bridge if it is five years old or older.

- **Recementing a bridge**, limited to a lifetime maximum of once per bridge.
- **Post and core buildups**, limited to once per tooth in a five year period.
- **Bridge repair**, limited to lifetime maximum of once per bridge.

Implants

Benefits for implants include:

- Surgical placement of implant
- Implant supported prosthetics
- Implant maintenance
- Repair of an implant
- Removal of an implant

Implants are limited to once per tooth in any ten benefit years (whether placement was under this Certificate or under any prior dental coverage).

Prosthodontics, Removable.

The Maximum Allowable Amount for these services includes routine post-delivery care. Covered Services include:

- Removable complete immediate or permanent and partial dentures, limited to once in five years. Benefits are available for the replacement of complete or partial dentures.

Covered Services for both complete and partial dentures include:

- **Adjustments**, limited to once per Appliance in a Benefit Period.
- **Repairs**, (unless repairs are completed on the same date as replacement partials/dentures), limited to once per Appliance per Benefit Period for partials/dentures.
- **Addition of tooth or clasp** (unless additions are completed on the same date as replacement partials/dentures), limited to a lifetime maximum of once per tooth.
- **Denture rebase and relining procedures**, limited to once in any three years for chairside or laboratory relining or rebasing.

Note: Covered Services for adjustments, repairs or rebasing/relining for both complete and partial dentures are covered.

Missing Tooth Benefit

Removable prosthodontics (partials or dentures) or fixed prosthodontics (bridges) for the replacement of teeth (or tooth) lost prior to the Member's Effective Date under this Certificate are covered.

Class IV - Orthodontic Services

Orthodontic Services

Non-surgical dental services related to the supervision, guidance, and correction of growing or mature teeth. Covered Services include examination, records, tooth guidance, and repositioning (straightening) of the teeth, as listed below.

Orthodontic benefits are paid on a quarterly basis and payment is made over the course of treatment, up to the maximum lifetime orthodontic benefit shown in the Schedule of Benefits. Orthodontic services are not subject to the annual benefit limit. **Refer to the Schedule of Benefits for Orthodontic Age Limitations.**

For each eligible Member, after the Deductible (if any) is met, the Plan pays the applicable percentage shown in the Schedule of Benefits of the Maximum Allowable Amount for the following orthodontic services:

- **Diagnostic orthodontic records**, limited to a lifetime maximum of once per eligible Member.
- **Minor treatment for tooth guidance.**
- **Minor treatment to control harmful habits.**
- **Interceptive orthodontic treatment.**
- **Comprehensive orthodontic treatment**, transitional and permanent dentition.
- **Post-treatment stabilization**, limited to a lifetime maximum of one Appliance per eligible Member.

Pretreatment Estimates and Treatment Plans

A Written Pretreatment Estimate is available from Us. Either you or your Provider may submit a request for a Pre-treatment

Estimate. In order for the Plan to complete a Pretreatment Estimate, your Provider will need to submit a written Treatment Plan, with the required documentation for the services. Requests should be submitted on a standard claim form. Telephone requests cannot be accepted. Mail the Pretreatment Estimate request and Treatment Plan forms to the address listed on your Identification Card.

The Plan will send to the Member and the Provider of service a written estimate of Covered Services, benefit amounts payable, Deductible amount due, and maximum limitation amounts. The Plan's Pretreatment Estimates are valid for

120 days, provided all other eligibility and Plan requirements are met. If the procedure is not completed within the time period set forth in the Pretreatment Estimate, or if the patient's condition changes, you should ask your Provider to submit another request and Treatment Plan, along with the required, current documentation. A new Pretreatment Estimate will then be completed by the Plan.

Regardless of a Pretreatment Estimate, coverage under this Certificate must be maintained without interruption through the date that services are performed in order for benefits to be provided.

9 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. This list of Exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Covered Services.

We do not provide benefits for services or supplies:

1. Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us.
2. Procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation.
3. 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.

4. To the extent that they are provided 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.
5. For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces;
6. For treatment of injuries sustained or illnesses resulting from participation in a riot or civil disturbance, or while committing or attempting to commit an assault or felony, unless otherwise required by law. For services, supplies or other care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
7. For court ordered care, unless authorized by Us.

8. For which you have no legal obligation to pay in the absence of this or like coverage;
9. 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;
10. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
11. For completion of claim forms or charges for medical/dental records or reports unless otherwise required by law.
12. For missed or canceled appointments.
13. Charges in excess of the Maximum Allowable Amount.
14. Incurred prior to your Effective Date.
15. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
16. Primarily for educational, vocational, or training purposes, except as otherwise specified herein.
17. Facility and professional charges such as charges billed by a hospital inpatient or outpatient or by an ambulatory surgical center or day surgery center.
18. For acid etch.
19. For analgesics (includes nitrous oxide).
20. For any duplicate prosthetic device or other Appliance, or for a "spare" set of dentures or any other duplicate Appliance such as, but not limited to, removable orthodontic retaining devices.
21. For athletic mouth guards.
22. For bacteriological studies for determination of pathologic agents.
23. For behavior management.
24. For biopsies except surgical biopsies.
25. For bleaching of discolored teeth.
26. For canal preparation and fitting of prefabricated dowel and post.
27. For caries susceptibility tests.
28. For chemical treatments.
29. For complications/services that are related to excluded services.
30. For cosmetic treatment intended primarily to improve appearance but not to restore body function or correct deformity from disease, trauma, or prior therapeutic processes.
31. For crown buildups on the same tooth as an amalgam or composite restoration that was done within the same Benefit Period.
32. For desensitizing medicaments and/or their application.
33. For diagnostic photographs, casts, or models.
34. For dietary instructions.
35. For discing.
36. For enamel microabrasion.
37. For fixed bridge when done in conjunction with a removable Appliance in the same arch.
38. For grafts to improve aesthetics.
39. For gold foil restorations;
40. For guided tissue regeneration.
41. For histopathological examinations.
42. For house/hospital calls.
43. For hypnosis.
44. For inlays and recementing of inlays.
45. For local anesthetic when billed separately.
46. For localized delivery of chemotherapeutic agents.
47. For mouth rehabilitation.
48. For mucogingival surgery.

49. For occlusal analysis.
50. For occlusal adjustments (complete or limited) except as specified otherwise in this Certificate.
51. For oral and inhalation sedation.
52. For oral hygiene instructions.
53. For OSHA fees and/or infection control fees when billed separately.
54. For polishing of restorations.
55. For post removal.
56. For precision attachments.
57. For prefabricated resin crown or stainless steel crown with resin window.
58. For prescription drugs.
59. For procedures performed in the absence of dental or gingival disease except for covered preventive and diagnostic care or Orthodontic Services.
60. For procedures, services and supplies to restore occlusion, vertical dimension or incisal edges due to bruxism, attrition or harmful habits.
61. For provisional splinting.
62. For pulp capping (direct or indirect).
63. For pulp vitality tests.
64. For pulpotomy on permanent teeth.
65. For rebonding of a Maryland bridge.
66. For recontouring.
67. For removable unilateral partial denture.
68. For replacement of a prosthodontic Appliance (fixed or removable) more often than once in any five-year period (measured from the date on which the replaced Appliance was last prepared for the Member, whether under this Certificate or under any prior dental coverage).
69. For replacement of restorations due to mercury or other possible allergies.
70. For replacement of serviceable prosthodontics (services needed to make an Appliance serviceable will be provided in accordance with this Certificate).
71. For resin crowns/onlays whether for single restorations, bridge retainers, or pontics.
72. For restorations on the same tooth as a previously placed sealant if fewer than two years have elapsed since the time sealants were placed.
73. For restoration overhang removal.
74. For root canal therapy on primary teeth.
75. For sealants on restored teeth (occlusal surface).
76. For second professional opinions.
77. For sedative fillings.
78. For services or supplies not specifically listed in this Certificate.
79. For silicate restorations.
80. For stress breakers.
81. For temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.).
82. For therapeutic injections.
83. For tissue conditioning procedures.
84. For tobacco-use counseling.
85. For travel expenses.
86. For two similar services performed at the same time where one service is an integral part of a more extensive procedure.
87. For upgrading of serviceable dentistry.
88. Related to temporomandibular joint (TMJ) dysfunction, therapy or surgery, regardless of the reason(s) such services are necessary.

10 CLAIMS PAYMENT

How to Obtain Benefits

For services received from a Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Providers will submit your claim for you. If you submit the claim use a claim form.

Maximum Allowed Amount

General

This section describes how We determine the amount of reimbursement for Dental Services. Reimbursement for dental services rendered by participating and non-participating Dentists is based on your plan's Maximum Allowed Amount for the type of service performed.

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

- that meet Our definition of Dental Services, to the extent such services and supplies are covered under your plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Certificate.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Dental Services from a non-participating Dentist, you may be responsible for paying any difference between the Maximum Allowed Amount and the Dentist's actual charges. This amount can be significant.

When you receive Dental Services from a Dentist, We will, to the extent applicable, apply claim processing rules to the claim submitted for

those Dental Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Dental Services you received were not Medically Necessary. It means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Dentist may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same dental provider or other dental providers, We may reduce the Maximum Allowed Amounts for those additional secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent a duplicate payment for a dental procedure that may have already been considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the provider is a participating Dentist or a non-participating Dentist.

Participating Dentist

A participating Dentist is a Dentist who is in the contracted network for this specific plan or who has a participation contract with Us. For Dental Services performed by a participating Dentist, the Maximum Allowed Amount for your plan is the rate the Dentist has agreed with Us to accept as

reimbursement for the Dental Services. Because participating Dentists have agreed to accept the Maximum Allowed Amount as payment in full for those Dental Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible, or have a copay or coinsurance. Please call Customer Service for help in finding a participating Dentist or visit www.anthem.com.

Non-Participating Dentist

Dentists who have not signed any contract with Us and are not in any of Our networks are non-participating Dentists.

For Dental Services You receive from a non-participating Dentist, the Maximum Allowed Amount for this plan will be one of the following as determined by Us:

1. An amount based on Our Non-Participating provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: record fee data, reimbursement amounts accepted by like/similar providers contracted with Us, reimbursement amounts accepted by like/similar providers for the same services or supplies, or other industry cost, reimbursement and utilization data; or
2. An amount based on information provided by a third party vendor which may reflect comparable Dentists' fees and costs to deliver care; or
3. An amount negotiated by Us or a third party vendor which has been agreed to by the participating Dentist; or
4. An amount equal to the total charges billed by the Dentist, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Dentists who are not contracted for this product but contracted for other products with Us are also considered non-participating. For your plan, the Maximum Allowed Amount for services from these Dentists will be one of the four methods shown above unless the contract between Us and that Dentist specifies a different amount.

Unlike participating Dentists, non-participating Dentists may send You a bill and collect for the amount of the Dentist's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Dentist charges. This amount can be significant. Choosing a participating Dentist will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a participating Dentist or visit Our website at www.anthem.com.

Customer Service is also available to assist you in determining your plan's Maximum Allowed Amount for a particular service from a non-participating Dentist. In order for Us to assist you, you will need to obtain from your Dentist the specific procedure code(s) for the services the Dentist will render. You will also need to know the Dentist's charges to calculate your out of pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Dentist.

Member Cost Share

For certain Dental Services and depending on your plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and out of pocket limits may vary depending on whether you received services from a participating or non-participating Dentist. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using non-participating Dentists. Please see the

Schedule of Benefits for your cost share responsibilities and limitations, or call Customer Service to learn how this plan's benefits or cost share amounts may vary by the type of Dentist you use.

We will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your Dentist for non-covered services, regardless of whether such services are performed by a participating or non-participating Dentist. Both services specifically excluded by the terms of your plan and those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, your annual or lifetime maximum, benefit maximums or day/visit limits.

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.

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 or any applicable state law.

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. An expense is considered incurred on the date the service or supply was given.

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. 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. 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.

Note: You have the right to obtain an itemized copy of your billed charges from the Hospital or facility which provided services.

Claim Forms

Many Providers will file for you. If the forms are not available, either 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

Proof of Claim

Written proof of claim satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. 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.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits

under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Member's Cooperation

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

Explanation of Benefits

After you receive dental 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 an action after the Appeals process.

11 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 dental care. Providers shall use their best efforts to render all dental 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 dental 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 in the case of the Provider, and to arrange care in the case of the Plan 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, labor disputes not within the control of the Plan, disability of a significant part of a Provider's personnel or similar causes, or the rendering of dental 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 Providers shall render dental care services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and 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

This Coordination of Benefits (COB) provision applies when you have dental care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Certificate, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Certificate, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

Because the Allowable expense may be the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider may be

allowed to bill you for any remaining Coinsurance, Deductible, and/or Copayment under the higher allowable amount. This higher allowable amount may be more than our allowed amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts

and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing dental care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing dental care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when you have dental care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health or dental care expense, including Deductibles and/or Coinsurance, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest

reimbursement amount for a specific benefit is not an Allowable expense.

2. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
3. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
4. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.

Closed panel plan is a Plan that provides dental care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent.

The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber

or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent child's dental care expenses or dental care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - If a court decree states that both parents are responsible for the Dependent child's dental care expenses or dental care coverage, the provisions of 1. above will determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental care expenses or dental care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
 - If there is no court decree assigning responsibility for the Dependent child's dental care expenses or dental care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by state or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable

expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other dental care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance and/or Deductible under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other dental care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and

other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. 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 the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1. We have paid or for whom We have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

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

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/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 the 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 Plan.
- 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 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:

1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
 2. 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 and 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 in which the Certificate is issued shall be applied to the interpretations of this Certificate.

Conformity with 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.

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. By electing dental coverage with 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.

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.

Medical Examination

We have the right to have a Physician examine you as often as is reasonably required while we are processing a claim. We will notify you in advance.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

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 covered, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowable Amount. However, a Member may utilize all applicable Member Grievance 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 Member Grievances 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.

Anthem Insurance Companies, Inc. Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this policy constitutes a contract solely between the Group and Anthem Insurance Companies, Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark 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.

12 MEMBER GRIEVANCES

Grievances

If you are dissatisfied with dental treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Dentist) to file a

Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a signed Designation of Representation

form is received.

We will accept oral or written comments, documents or other information relating to the grievance 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, all documents, records, and other information relevant to the Member's appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-627-0004 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing. If you wish to file your Grievance in writing, mail it to: Anthem Blue Cross and Blue Shield, Grievance Department, P.O. Box 659471, San Antonio, TX 78265-9471.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 5 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your 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. You will be given at least 72 hours advance notice of the date and time of the panel meeting. The panel will resolve all other Appeals no later than 45 business days from the date your 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 Appeal.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is received by Us after the end of the calendar year plus 12 months have passed since the incident leading to your Grievance. We will accept Appeals filed within 60 days after you are notified of our decision concerning your Grievance.

Grievances and 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 Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is 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 an Appeal is pending. You will be notified of your right to file a voluntary Appeal if Our response to your Grievance is adverse. Upon your request, We will also provide you with detailed information concerning an Appeal, including how panelists are selected.

Department of Insurance

You have a right, when encountering a problem with Us, to contact the Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204, (317) 232-2385.



Underwritten by Anthem Insurance Companies, Inc.

Your Vision Certificate

Vision Certificate of Coverage

(herein called the "Certificate")

Blue View Vision

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

CERTIFICATE

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

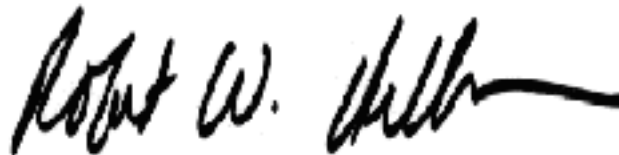
The coverage described in this Certificate is subject in every respect to the provisions of the Group Contract issued to the Group. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services and supplies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

A handwritten signature in black ink, appearing to read "Robert W. Hill", followed by a long horizontal flourish.

President

Contents

1	SCHEDULE OF BENEFITS	V-7
2	DEFINITIONS	V-8
3	ELIGIBILITY AND ENROLLMENT	V-10
	Eligibility	V-10
	Dependents	V-10
	College Student Medical Leave	V-11
	Enrollment	V-11
4	TERMINATION AND CONTINUATION	V-14
	Termination	V-14
	Removal of Members	V-15
	Reinstatement	V-15
	Continuation	V-15
	Continuation of Coverage Due To Military Service	V-17
	Family and Medical Leave Act of 1993	V-18
5	HOW TO OBTAIN COVERED SERVICES	V-18
	Network Services and Benefits	V-18
	Relationship of Parties (Plan - Network Providers)	V-18
	Not Liable for Provider Acts or Omissions	V-19
6	COVERED SERVICES	V-19
	Vision Eye Examination	V-19
	Eyeglass Lenses	V-19
	Frames	V-20
	Elective Contact Lenses	V-20
	Non-Elective Contact Lenses	V-20
	Cosmetic Options	V-20
7	EXCLUSIONS	V-21
8	CLAIMS PAYMENT	V-22
	Obtaining Services/Claim Payment	V-22
	Assignment	V-22
	Notice of Claim	V-22
	Claim Forms	V-22
	Proof of Claim	V-23
	Time Benefits Payable	V-23
	Member's Cooperation	V-23
	Explanation of Benefits	V-23
9	GENERAL PROVISIONS	V-23
	Entire Contract	V-23
	Form or Content of Certificate	V-24
	Circumstances Beyond the Control of the Plan	V-24
	Coordination of Benefits	V-24
	Other Government Programs	V-24
	Right of Recovery	V-24
	Relationship of Parties (Group-Member-Plan)	V-24
	Conformity with Law	V-25

Modifications	V-25
Clerical Error	V-25
Legal Action	V-25
Policies and Procedures	V-25
Waiver	V-25
Plan's Sole Discretion	V-25
Reservation of Discretionary Authority	V-25
Anthem Blue Cross and Blue Shield Note	V-26
10 COMPLAINT AND APPEALS PROCEDURES	V-26
The Complaint Procedure	V-26
The Appeals Procedure	V-27
Contact Person For Appeals	V-27
Vision Services	V-28
Limitation of Actions	V-28

1 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the amount of benefits available when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific vision services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Certificate including any attachments or riders.

CHOICE OF VISION CARE PROVIDER: Nothing contained in this Certificate restricts or interferes with your right to select the Vision Care Provider of your choice, but your benefits are reduced when you use a Non-Network Provider.

DEPENDENT AGE LIMIT

To the end of the month in which the child attains age 26

COVERED SERVICES

COPAYMENT/MAXIMUMS

Exam

Network
\$10 Copayment

Non-Network
Reimbursed up to \$42

Limited to one exam per Member every 12 months.*

Prescription Lenses (including factory scratch coating polycarbonate lenses for children under 19 years old and Photochromic lenses for children under 19 years old.) \$20 Copayment

Basic Lenses (Pair)

- Single Vision Lenses
- Bifocal Lenses
- Trifocal Lenses

Reimbursed up to \$40
Reimbursed up to \$60
Reimbursed up to \$80

Limited to one set of lenses per Member every 12 months*

Frames (Limited to one set of frames per Member every 24 months *)

\$0 Copayment Any frame up to \$130 retail

Reimbursed up to \$45

Prescription Contact Lenses

(traditional or disposable)

- **Non-Elective Contact Lenses** (Availability once every 12 months *) \$0 Copayment Non-Elective Contact Lenses are Reimbursed up to \$210

- **Elective Contact Lenses** \$0 Copayment Elective Contact Lenses are Reimbursed up to \$105
(Availability once every 12 months*)

Note: If you chose covered Non-Elective Contact Lenses or Elective Contact Lenses, no benefits will be available for covered eyeglass lenses and frames in that period.
* from the Last Date of Service.

Laser Vision Correction Services

Participating Lasik/photorefractive keratectomy PRK surgical centers offer a discounted rate for Members enrolled under this plan. You are responsible for any remaining charges.

2 DEFINITIONS

This section defines terms that 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.

Additional Savings Program – A discount program included in the vision benefit program. It can be used with certain non-covered services and plan overages. The discount plan is subject to change at any time.

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

Group Contract and is subject to the terms of the Group Contract.

Coinsurance - A percentage of the Maximum Allowable Amount for which you are responsible to pay. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment - A specific dollar amount indicated in the Schedule of Benefits for which you are responsible.

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

- Within the scope of the license of the Provider performing the service;

- Rendered while coverage under this Certificate is in force;
- Within the Maximum Allowable Amount;
- Not specifically excluded or limited by the Certificate;
- Specifically included as a benefit within the Certificate.

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

Dependent - A Subscriber's spouse and dependent children who have met Our eligibility requirements and have not reached the age limit shown in the Schedule of Benefits.

Effective Date - The date when your coverage begins under this Certificate. A Dependent's coverage begins on the Effective Date of the sponsoring Subscriber.

Elective Contact Lenses - All prescription contact Lenses that are cosmetic in nature or Non-Elective Contact Lenses.

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

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).

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Group - The employer or other entity or trust 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 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.

Last Date of Service - The period of time in which benefits are tracked. The Member must

wait until the specific interval from the last date of service to receive Covered Services as listed in the Schedule of Benefits.

Late Enrollee - An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under this Certificate, and who did not qualify for Special Enrollment.

Lenses - Materials prescribed for the visual welfare of the patient. Materials would include single vision, bifocal, trifocal or other more complex lenses.

Maximum Allowable Amount - The maximum amount allowed for Covered Services you receive based on the fee schedule. The Maximum Allowable Amount is subject to any Copayments, Coinsurance, limitations or Exclusions listed in this Certificate.

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.

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

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."

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

Non-Elective Contact Lenses - Contact

Lenses which are provided for reasons that are not cosmetic in nature. Non-Elective Contact Lenses are Covered Services when the following conditions have been identified or diagnosed:

- Extreme visual acuity or other functional problems that cannot be corrected by spectacle Lenses; or
- Keratoconus-unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or
- High Ametropia-unusually high levels of near sightedness, far sightedness, or astigmatism are identified; or
- Anisometropia-when one eye requires a much different prescription than the other eye.

Non-Network Provider - A Provider who has not entered into a contractual agreement with Us for the Network associated with this Certificate.

Open Enrollment – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; see the Eligibility and Enrollment section for more information.

Plan (or We, Us, Our) – Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield which provides benefits to Members for the Covered Services that are described in this Certificate.

Premium - The periodic charges that the Member or the Group must pay the Plan to maintain coverage.

Provider - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that We approve. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider.

Subscriber - An eligible employee or Member of the Group who is eligible to receive benefits under the Group Contract.

3 ELIGIBILITY AND ENROLLMENT

You have coverage provided under this Certificate because of your employment with/membership with/ retirement from the Group. You must satisfy certain requirements to participate in the Group's benefit plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by the Group or state and/or federal law and approved by Us.

Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.

Eligibility

The following eligibility rules apply unless you are notified by Us and the Group.

Subscriber

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

- Be either: An employee, Member, or retiree of the Group, and;
- Be entitled to participate in the benefit plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and be Actively At Work;
- Meet the eligibility criteria stated in the Group Contract.

Dependents

To be eligible 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 spouse as recognized under the laws of the state where the Subscriber lives.
- The Subscriber's or the Subscriber's spouse's natural children, newborn and legally adopted children, stepchildren, children for whom the Subscriber or the Subscriber's spouse is a legal guardian, or children who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.
- The following children, if the Subscriber provides more than fifty percent (50%) of the child's total support: the Subscriber's or the Subscriber's spouse's grandchildren or other blood relatives.

All enrolled eligible, 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 Dependents who cannot work to support themselves due to mental retardation or physical or mental handicap. 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 120 days after the Dependent would normally become ineligible. You must notify Us if the Dependent's 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.

College Student Medical Leave

The Plan will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a Medically Necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless Dependent coverage ends earlier under another Plan provision, such as the parent's termination of employment or the child's age exceeding the Plan's limit.

Medically Necessary change in student status. The extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a Medically Necessary leave of absence or a change in enrollment status (for example, a switch from full-time to part-time student status). The Plan must receive written certification from the child's Physician confirming the serious illness or injury and the Medical Necessity of the leave or change in status.

Enrollment

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to the Plan. The application must be received by the date stated on 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 during the Open Enrollment period or during a Special Enrollment period, which ever is applicable.

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for

coverage during the Open 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

Any Dependent child born while the Subscriber or Member's spouse is eligible for coverage will be covered from birth for a period of 31 days. Any Dependent child adopted while the Subscriber or the Member's spouse is eligible for coverage will be covered from the date of placement for purposes of adoption for a period of 31 days.

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, and will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

To continue coverage beyond the 31 day period after the child's birth or adoption, you must notify Us by submitting a Change of Status Form to add the child under the Subscriber's Certificate. The Change of Status Form must be submitted within 31 days after the birth or placement of the child. If timely notice is given, an additional Premium for the coverage of the newborn child or adopted child will not be charged for the duration of the notice period. However, if timely notice is not given, We may charge an additional Premium from the child's date of birth or placement for adoption.

If the child is not enrolled within 31 days of the date of birth or placement for adoption, coverage will cease.

Adding a Child due to Award of Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days

of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship. If We do not receive an application within the 31-day period, the child will be treated as a Late Enrollee.

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 shall provide the benefits of this Certificate in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit 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.

Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other vision 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.

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or CHIP.

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If We receive an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, that person is only eligible for coverage as a Late Enrollee.

Application forms are available from the Plan.

Late Enrollees

You are considered a Late Enrollee if you are an Eligible Person or Dependent who did not request enrollment for coverage:

- During the initial enrollment period; or
- During a 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 you were first entitled to enroll.

You may apply for coverage at any time during the year as a Late Enrollee. However, you will not be enrolled for coverage with the Plan until the next Open Enrollment Period.

Open Enrollment Period

An Eligible Person or Dependent who did not request enrollment for coverage during the initial enrollment period, or during a Special Enrollment

period, may apply for coverage at any time, however, will not be enrolled until the Group's next annual enrollment.

Open Enrollment means a period of time (at least 31 days prior the Group's renewal date and 31 days following) which is held no less frequently than once in any 12 consecutive months.

Notice of Changes

The Subscriber is responsible to notify the Group of any changes that 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 dental plan. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of payments from the Group for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 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.

A Member's coverage terminates on the date such Member ceases to be in a class of Members eligible for coverage. 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.

Effective Date of Coverage

For information on your specific Effective Date of Coverage under this Certificate, please see your human resources or benefits department. You can also contact Us by calling the number located on the back of your Identification (ID) Card or by visiting www.anthem.com.

Statements and Forms

Subscribers or applicants for membership shall complete and submit applications, questionnaires or other forms or statements the Plan may

reasonably request.

Applicants for membership understand that all rights to benefits under this Certificate are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by a Member may result in termination of coverage as provided in the "Changes in Coverage: Termination, Continuation & Conversion" section.

Delivery of Documents

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

4 TERMINATION AND CONTINUATION

Termination

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 Employer's specific requirements:

- If you terminate your coverage, termination will generally be effective on the date of termination in which We received 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 date of termination. 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, except when indicated otherwise in the Schedule of Benefits. We will also terminate your Dependent's coverage, generally effective on the date your coverage is terminated. We will notify the Group in the event We terminate you and your Dependent's coverage.

- A Dependent's coverage will generally terminate on the date of termination in which notice was received by Us that the person no longer meets the definition of Dependent, except when indicated otherwise in the Schedule of Benefits.
- 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 vision 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 Certificate, then coverage for you and your Dependents will generally terminate on the date of termination 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 permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for services received through such misuse.

Removal of Members

Upon written request through the Group, a Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

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 you 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 the Group's clerical error.

Continuation

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under a Group 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 Group's vision plan. It can also become available to other Members of your family, who are covered under the Group's vision plan, when they would otherwise lose their vision

coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Group's vision plan, you should contact the Group.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of vision coverage under the Group's vision 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 Group's vision plan is lost because of the qualifying event. Under the Group's vision plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Group for Premium payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's vision 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 Group's vision 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; or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Group's vision 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 parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Group's vision plan as a "Dependent child."

If Your Group 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 Group, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Group's vision 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 Group's vision plan.

When is COBRA Coverage Available

COBRA continuation coverage will be offered to qualified beneficiaries only after the Group 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 Group 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 Group within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the Group 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 Group's vision plan is determined by the Social Security Administration to be disabled and you notify the Group 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 Group. 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 Group's vision plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Group's vision plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA,

including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group 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.)

Continuation of Coverage Due To Military Service

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

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

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate 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 (24 months if continuation is elected on or after 12/10/2004) beginning on the first date of your absence from work; 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 underwriting and without imposition of an additional waiting period. 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.

5 HOW TO OBTAIN COVERED SERVICES

Network Services and Benefits

If a Network Provider renders your care, benefits will be provided at the Network level. Refer to the Schedule of Benefits. No benefits will be provided for care that is not a Covered Service even if performed by a Network Provider.

We may inform you that a service you received is not a Covered Service under the Certificate. You may appeal this decision. See the Complaint and Appeals Procedures section of this Certificate.

Network Providers are professional Providers and other facility Providers who contract with Us to perform services for you. You will not be required to file any claims for services you obtain directly from Network Providers.

Non-Network Services and Benefits

Services that are not obtained from a Network Provider will be considered a Non-Network Service. In addition, certain services may not be covered unless obtained from a Network Provider, and/or may result in higher cost-share amounts. See your Schedule of Benefits. You will be required to file claims for services that you obtain directly

from a Non-Network Provider.

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 Provider or in any 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. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or Us.

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 of vision care, services or supplies, does or does not do.

6 COVERED SERVICES

This section describes the Covered Services available under your vision care benefits when provided and billed by eligible Providers. All Covered Services are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the Certificate. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Schedule of Benefits.

The following are Covered Services:

- Routine Vision examinations
- Standard Eyeglass Lenses
- Frames
- Contact Lenses in lieu of Eyeglass Lenses

Services and materials obtained through a Non-Network Provider are subject to the same Exclusions and limitations as services through a Network Provider.

If you choose a set of frames that are valued at more than the Maximum Allowable Amount, you are responsible for the difference in cost.

If a Member elects either covered Non-Elective or Elective Contact Lenses within one 12-month period, no benefits will be paid for covered Lenses and frames until the next 12-month period.

Vision Eye Examination

The Plan covers up to a comprehensive eye examination including dilation as needed minus

any applicable Copayment. The eye examination may include the following:

- Case history
- Recording corrected and uncorrected visual acuity
- Internal exam
- External exam
- Pupillary reflexes
- Binocular vision
- Objective refraction
- Subjective refraction
- Glaucoma test
- Slit lamp exam (Biomicroscopy)
- Dilation
- Color vision
- Depth perception
- Diagnosis and treatment plan.

Eyeglass Lenses

Eyeglass Lenses are available in standard or basic plastic (CR39) Lenses including single vision, bifocal, and trifocal with factory coating with polycarbonate lenses for children under 19 and photochromic lenses for children under 19. If you choose progressive Lenses that are no line bifocals, there will be an additional cost. All eyeglass Lenses are subject to the applicable

Copayment listed in the Schedule of Benefits. There may also be an additional cost for any add-ons to the Lenses such as anti-reflective coating or ultra-violet coating. These and any other lens add-ons may be discounted according to Our Additional Savings Program.

Frames

The frame allowance is based upon the retail cost. The Member may apply the plan allowance toward the Network Provider's selection of frames. The Schedule of Benefits lists the frames allowance available under your plan. If you choose a set of frames that are valued at more than the Maximum Allowable Amount, you are responsible for the balance based upon the Additional Savings Program.

Elective Contact Lenses

The contact lens allowance must be completely used at the time of initial service. No amount of the allowance may be carried forward to use during another service date. The Schedule of Benefits lists the contact lens allowance available under this Certificate.

Non-Elective Contact Lenses

This benefit is available for a limited number of diagnoses and is in lieu of the standard contact lens or Lenses and frames benefit.

Eligibility

Conditions that provide eligibility for consideration of this Non-Elective Contact Lens benefit include:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle Lenses.
- High Ametropia exceeding -12 D or +9 D in spherical equivalent.

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

Fitting Fees

The Member is responsible for 100% of the fitting fee at the time of service. However, Our Maximum Allowable Amount reimbursement paid to the prescribing Provider for Non-Elective Contact Lenses may include a portion, or all, of the fitting fee. Any remaining amount will be applied to the Provider's fitting fee.

SPECIAL NOTE: We will not reimburse for Non-Elective Contact Lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Cosmetic Options

Benefits are available for the services below in accordance with the Additional Savings Program. The Member will be responsible for the following items at a discounted rate when provided by a Network Provider.

- Blended Lenses
- Contact Lenses (except as noted herein)
- Oversize Lenses
- Progressive multifocal Lenses
- Photochromatic Lenses, or tinted Lenses
- Coated Lenses
- Frames that exceed the Maximum Allowable Amount
- Cosmetic Spectacle Lenses
- Ultra-violet coating
- Scratch resistant coating
- Polycarbonate Lenses

- Anti-reflective coating

- Optional cosmetic items

7 EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Covered Services.

We do not provide vision benefits for services, supplies or charges:

1. Received from an individual or entity that is not a Provider, as defined in this Certificate.
2. 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. 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.
3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
4. For illness or injury that occurs as a result of any act of war, declared or undeclared.
5. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. Received from an optical or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
8. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
9. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
10. For missed or canceled appointments.
11. In excess of Maximum Allowable Amount.
12. Incurred prior to your Effective Date.
13. Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
14. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
15. For sunglasses and accompanying frames.
16. For safety glasses and accompanying frames.
17. For inpatient or outpatient hospital vision care.
18. For Orthoptics or vision training and any associated supplemental testing.
19. For non-prescription lenses.
20. For two pairs of glasses in lieu of bifocals.
21. For Plano lenses (lenses that have no refractive power).
22. For medical or surgical treatment of the eyes.
23. For lost or broken Lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
24. For services or supplies not specifically listed in the Certificate.

25. Certain brands on which the manufacturer imposes a no discount policy.

26. For services or supplies combined with any other offer, coupon or in-store advertisement.

8 CLAIMS PAYMENT

Obtaining Services/Claim Payment

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. If you elect to obtain services from a Non-Network Provider, you must pay the entire bill at the time the services are rendered. To request reimbursement for Covered Services We will need the following information:

- The name, address and phone number of the Non-Network Provider along with an itemized statement of charges
- The covered Member's name and address, group number, Social Security number or Member identification number
- The patient's name, birthdate and relationship to the Member

The Member should keep a copy of the information and send the originals to the following address:

BlueView Vision Claims Administration
PO Box 8504
Mason, OH 45040-7111

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. An expense is considered incurred on the date the service or supply was given.

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. 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 can be submitted later than one year after the usual 90 day filing period ends. 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.

Claim Forms

Many Providers will file for you. If the forms are not available, either 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

Proof of Claim

Written proof of claim satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to do send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. 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. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We 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.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Certificate, We may reimburse those

other parties and be fully discharged from that portion of its liability.

Member's Cooperation

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

Explanation of Benefits

After you receive vision care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you received. 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 an action after the Appeals process.

9 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.

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, labor disputes not within the control of the Plan, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of vision 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 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

We consider this Plan primary in all circumstances.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under this Certificate 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.

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 12 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 and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, or Vendor resulting from these audits if the return of the overpayment is not feasible. 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 termination's.

Conformity with Law

Any provision of this Plan that 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.

Modifications

This Certificate allows the Group to make 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 permission or involvement of any Member. Changes will not be effective until 30 days after We provide written notice to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Certificate.

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.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Complaint and Appeals Procedures before filing a lawsuit or other legal action of any kind against Us.

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, is able to disregard any conditions or restrictions contained in this Certificate, to extend the amount of 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, in 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 covered. However, a Member may utilize all applicable Grievance 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 Member Grievances 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.

Anthem Blue Cross and Blue Shield Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate constitutes a contract solely between the Group and Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark 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.

10 COMPLAINT AND APPEALS PROCEDURES

Our customer service representatives are specially trained to answer your questions about Our vision benefit plans. 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;
- Providers in the Network; and/or
- Provider directories.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the Appeals Procedure.

A Complaint Procedure also exists to help you understand the Plan's determinations.

The Complaint Procedure

A Complaint Procedure is available to provide reasonable, informative responses to complaints that you may have concerning the Plan. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Plan of its procedures and contracts. The Plan invites you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by Vision Providers in the Plan's Networks.

If you have a complaint or problem

concerning benefits or services, please contact Us. Please refer to your Identification Card for Our address and telephone number. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint.

Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within six months after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

The Appeals Procedure

An appeal is a formal request from you for the Plan to change a previous determination. If you are notified in writing of a Coverage Denial or any other adverse decision by Us, you will be advised of your right to an internal appeal.

A Coverage Denial means Our determination that a service, treatment, drug or device is specifically limited or excluded under this Certificate.

The internal appeals process may be initiated by the Member, the Member's authorized representative, or a Provider acting on behalf of the Member within 60 days of receipt of Our written notice of a Coverage Denial, or any other adverse decision made by Us, but must be filed within six months of your receipt of the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by the Member relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. 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.

If a representative is seeking an appeal on behalf of a Member, We must obtain a signed

Designation of Representation (DOR) form from the Member. The appeal process will not begin until Anthem has received the properly completed DOR. We will forward a Designation of Representation form to the Member for completion.

The individuals responsible for reviewing your request for an internal appeal will not be the same individuals who made the initial denial or determination. They will not be the subordinates of the initial decision-maker either and no deference will be given to the initial decision.

Within a reasonable period of time but no later than 30 days after receiving a written or an oral request for an appeal, We will send a written decision to the Member or their authorized representative.

Contact Person For Appeals

The request for an internal appeal must be submitted to the following address or telephone number or to the appeal address or telephone number provided on your written notice of an adverse decision:

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

Telephone Number: 866-723-0515

The person holding the position named above will be responsible for processing your request.

The Plan encourages its Members to submit requests for appeal in writing. The request for appeal should describe the problem in detail. Attach copies of bills, medical records, or other appropriate documentation to support the appeal that may be in your possession.

You must file appeals on a timely basis. As state above, you are encouraged to file internal appeals within 60 days of your receipt of the Plan's initial decision. Internal appeals must be filed, however, within six months of your receipt of the initial decision.

Vision Services

We are not liable for the furnishing of Covered Services, but merely for the payment of them. You shall have no claim against Us for acts or omissions of any Provider from whom you receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

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 three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure before filing a lawsuit or other legal action of any kind against the Plan. If your vision benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

Indiana
Life and Health
Insurance
Guaranty
Association
Disclaimer

Notice Of Protection Provided By The Indiana Life And Health Insurance Guaranty Association

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only to for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 in basic hospital, medical and surgical or major medical insurance benefits
- \$300,000 in disability and long term care insurance
- \$100,000 in other types of health insurance

Annuities

- \$250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- \$5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity, or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
8777 Purdue Road, Suite 360
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.



Underwritten by Anthem Insurance Companies, Inc.

Notice of Privacy Practices



Information That's Important to You

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

Want to save more trees? Go to anthem.com and sign up to receive these types of notices by e-mail.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide. You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI — unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.
- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Anthem, Anthem does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Anthem does not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective Date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated in the footer of this Notice.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance. Contact your Plan administrator for more information.

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In most of Missouri: RightCHOICE[®] Managed Care, Inc. (RIT), Healthy Alliance[®] Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross and Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. [®] ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.