Matthew Thornton Blue
Subscriber Certificate

What You Need to Know about Your Group Managed Health Care Plan

This insured product is under the jurisdiction of the New Hampshire Insurance Department.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the Customer Service. The toll-free telephone number is 1-800-870-3057.

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

† This health plan is administered by Anthem Blue Cross and Blue Shield and is underwritten by Matthew Thornton Health Plan, Inc.

Anthem Blue Cross and Blue Shield is located at 3000 Goffs Falls Road, Manchester, New Hampshire 03111-0001

Our toll-free telephone number is 1-800-870-3057
Welcome!
Anthem Blue Cross and Blue Shield (Anthem) welcomes you to the family of Members who have selected this managed health care plan to meet their health Benefit needs. Your membership is appreciated! Please contact Anthem with your questions, concerns or suggestions. Anthem’s Customer Service Representatives are available during business hours to assist you. When you call or write, please provide the identification number listed on your identification card so that Anthem’s representatives can assist you without delay.

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Please visit Anthem’s website at www.anthem.com

Lisa M. Guertin
President and General Manager
New Hampshire

Kathleen S. Kiefer
Corporate Secretary

This product is administered by Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield (Anthem). Anthem is a stock corporation and licensed Accident and Health insurer in the State of New Hampshire. The Benefits described in this Certificate are underwritten by Matthew Thornton Health Plan, Inc., a wholly-owned subsidiary of Anthem. Matthew Thornton Health Plan, Inc. is licensed in the State of New Hampshire as a health maintenance organization. The Benefits described in this Certificate are provided in accordance with requirements of New Hampshire statutes applicable to Accident and Health Insurance and Health Maintenance Organizations. Anthem and Matthew Thornton Health Plan, Inc. are independent licensees of the Blue Cross and Blue Shield Association.
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SECTION 1 OVERVIEW – HOW YOUR PLAN WORKS

Please see Section 14, “Definitions” for definitions of specially capitalized words.

I. About This Certificate

This is your Subscriber Certificate. It describes a partnership between you, your physician, your Group and Anthem. You are entitled to the Benefits described in this Certificate. Certain rights and responsibilities are also described in this Certificate.

Your Cost Sharing Schedule is an important part of this Certificate. It lists your cost sharing amounts and certain Benefit limitations. Riders, endorsements or other amendments that describe additional Covered Services or limitations may also be issued to you. Please read your Certificate, Cost Sharing Schedule, riders, endorsements and amendments carefully, because they explain the terms of your coverage.

II. Your Primary Care Provider (PCP)

In this Certificate, your Primary Care Provider is called your PCP. To be eligible for Benefits, each Member must select a PCP at enrollment time. PCPs include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), and pediatricians.

To select your PCP, use the provider directory, which Anthem makes available at enrollment time. Or, call Customer Service for assistance. The toll-free telephone number is 1-800-870-3057.

Your PCP is a physician who becomes familiar with your medical history, furnishes your primary care and coordinates other health care services. Always talk to your PCP before you receive health care services. If you need specialized care, your PCP will coordinate your care by working with the hospitals, specialists and suppliers in the Network and by authorizing any required Referral for Network Services in advance. Your PCP must authorize a Referral for Out-of-Network Services in advance. Benefits will be denied if you do not obtain your PCP’s Referral as required. Please see Sections 3, “Access to Care Through Your Primary Care Provider (PCP)” and 4, “Open Access to Care” for more information.

III. The Network

Network Providers are physicians, including Primary Care Providers (internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN) and pediatricians) and specialists, hospitals and other health care providers and facilities that have a network payment agreement directly with Anthem Health Plans of New Hampshire, Inc., (Anthem) to provide Covered Services to Members. Network Providers are listed in the provider directory. Since the printed directory is updated periodically, your directory book may not always be current at the time you need to arrange for Covered Services. To locate the most up-to-date information about Network Providers, please go to Anthem’s website, www.anthem.com. Or, you may contact Customer Service for assistance. The toll-free telephone number is 1-800-870-3057.

Network Providers are independent contractors who furnish Covered Services to Members. Anthem does not, nor does it intend to, engage in the performance or delivery of medical or hospital services or other types of health care.

Payment agreements may include financial incentives or risk sharing relationships related to provision of services or Referrals to other Network Providers, Out-of-Network Providers and disease management programs. Financial incentives for cost-effective care are consistent with generally recognized professional standards. If you have questions regarding such incentives or risk sharing relationships, please contact your provider or Anthem.
Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Subcontractors may include but are not limited to prescription drugs and Behavioral Health Care. Such subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, network management or customer service duties on Anthem’s behalf.

The selection of a Network Provider or any other provider and the decision to receive or decline to receive health care services is the sole responsibility of the Member. Contracting arrangements between Network Providers and Anthem should not, in any case, be understood as a guarantee or warranty of the professional services of any provider or the availability of a particular provider.

Physicians, hospitals, facilities and other providers who are not Network Providers are Out-of-Network Providers.

### IV. Group Coverage

You are covered under this Certificate as part of a Group. Your Group and Anthem determine eligibility rules. Your Group acts on your behalf by sending to Anthem the premium to maintain your coverage. Premium rates accepted by your Group at initial enrollment or at the Group’s annual renewal are guaranteed for 12 months from the effective date of the Group’s coverage. Premium rates may change if your Group changes the plan offered to employees or on the date of your Group’s annual renewal. Anthem will notify your Group of any renewal premium increase at least 60 days before your Group’s annual renewal date.

By completing the enrollment process and enrolling in this health plan, you authorize your Group to make premium payments to Anthem on your behalf, and you agree to the terms of this Certificate. Provided that the required premium is paid on time, your coverage becomes effective on a date determined by your Group and by Anthem and as required by law.

### V. Services Must be Medically Necessary

Each Covered Service that you receive must be Medically Necessary. Otherwise, no Benefits are available. This requirement applies to each Section of this Certificate and to the terms of any riders, endorsements or amendments. The definition of Medical Necessity is stated in Section 14, “Definitions.”

Anthem may review services after they have been furnished in order to confirm that they were Medically Necessary. Network Providers are prohibited from billing you for care that is not Medically Necessary unless:

- You sign an agreement with the provider accepting financial responsibility for services, and/or
- The services are not Covered Services or are subject to a limitation or exclusion as described in this Certificate.

No Benefits are available for services that are not specifically described as Covered Services in this Certificate.
SECTION 2: COST SHARING TERMS

Please see Section 14, “Definitions” for definitions of specially capitalized words.

Under this managed health care plan, you share the cost of certain Covered Services. Please see your Cost Sharing Schedule for specific cost sharing amounts.

Depending on the plan chosen by your Group, you will find some or all of the following terms on your Cost Sharing Schedule:

I. Copayments

Copayments are fixed dollar amounts that you pay each time you receive certain Covered Services. The following is not a complete list of Copayment requirements that may apply under the plan chosen by your Group. Other Copayment requirements may be explained on your Cost Sharing Schedule or in riders or endorsements that amend this Certificate.

A Visit Copayment applies to Outpatient visits for medical/surgical care and Behavioral Health Care. Depending on the plan chosen by your Group, Copayment amounts may vary according to the type of provider you visit. For example, the Copayment for a visit to your Primary Care Provider (PCP) may be less than the Copayment for a visit to a specialist.

An Outpatient Surgery Copayment applies each time you have surgery or deliver a baby in an Outpatient surgical facility such as the Outpatient department of a hospital, an ambulatory surgical center or a Birthing Center. This Copayment does not apply to office surgery, Outpatient hemodialysis or surgery performed during an emergency room visit for Emergency Care.

The Emergency Room Copayment applies each time you use the emergency room at a hospital. This Copayment is waived if you are admitted to the hospital for Inpatient care directly from the emergency room. The Urgent Care Facility Copayment applies each time you visit a Network Urgent Care Facility for diagnosis, care and treatment of an illness or injury. Please see Section 14, “Urgent and Emergency Care” for more information about urgent care. Please note: In addition to the Emergency Room Copayment or Urgent Care Facility Copayment, a Deductible and/or Coinsurance may apply. For example, your plan may include a Deductible and Coinsurance for the physician and ancillary services furnished during your visit. Please refer to your Cost Sharing Schedule for more information about your share of the cost for “Emergency Room Visits and Urgent Care Facility Visits.”

Depending on the plan chosen by your Group, the Specialty Visit Copayment or the Walk-In Center Copayment applies each time you visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of illness or injury. See Section 6, “Urgent and Emergency Care” for more information. Please note: In addition to the Copayment, a Deductible and/or Coinsurance may apply. For example, your plan may include a Deductible and Coinsurance for diagnostic tests, medical supplies and drugs administered during a visit to a Network Walk-In Center. Please refer to your Cost Sharing Schedule for more information about your share of the cost for “Medical/Surgical Care in a Physician’s Office.”

An Inpatient Copayment applies each time you are admitted as a bed patient to a Short Term General Hospital or to an eligible facility for Inpatient Behavioral Health Care. Depending on the plan chosen by your Group, an Inpatient Copayment may also apply to Skilled Nursing Facility and/or Physical Rehabilitation Facility Inpatient admissions.

A Therapy Copayment applies each time you receive physical, occupational or speech therapy in an office or other Outpatient setting, such as in a Short Term General Hospital or Skilled Nursing Facility. Note: the Therapy Copayment does not apply to physical, occupational or speech therapy furnished as part of an Early Intervention Program.
program, but other cost sharing amounts may apply as shown in part III of your Cost Sharing Schedule, “Outpatient Physical Rehabilitation Services.”

A **Diagnostic Test Copayment** applies each time you receive one of the diagnostic tests listed on your Cost Sharing Schedule.

**Prescription Drug Copayments.** Prescription Drug Copayments apply as shown on your Cost Sharing Schedule and as described in your Pharmacy Rider.

## II. Deductible

A Deductible is a fixed dollar amount that you pay for each Member’s Covered Services each Calendar Year before Benefits are available for payment under this Certificate. The following is not a complete list of Deductible requirements that may apply under the plan chosen by your Group. Other Deductible requirements may be explained on your Cost Sharing Schedule or in riders or endorsements that amend this Certificate.

The **Standard Deductible** applies to all Covered Services. Any exceptions are stated on your Cost Sharing Schedule.

The **Inpatient Deductible** applies only to Inpatient hospital care. It applies to any Inpatient admission to a Short Term General Hospital, Skilled Nursing Facility, Physical Rehabilitation Facility or an eligible facility for Inpatient Behavioral Health Care. Inpatient facility and professional fees are subject to this Deductible before Benefits are paid for each Member’s Inpatient care each Calendar Year.

A separate Deductible may apply to durable medical equipment, medical supplies and prosthetics, as described in Section 7 “Covered Services,” IV “Durable Medical Equipment, Medical Supplies and Prosthetics.” If your Group has purchased a Pharmacy Rider, a separate Deductible may apply to pharmacy purchases. These Deductibles are shown on your Cost Sharing Schedule and do not count toward meeting any other Deductible amounts.

## III. Coinsurance

After any applicable Deductible is met, Anthem pays a percentage of the cost of certain Covered Services. You also pay a percentage. The percentage that you pay is called “Coinsurance.” Coinsurance applies to Covered Services as shown on your Cost Sharing Schedule. The following is not a complete list of Coinsurance requirements that may apply under the plan chosen by your Group. Other Coinsurance requirements may be explained on your Cost Sharing Schedule or in riders or endorsements that amend this Certificate.

**Standard Coinsurance** applies to all Covered Services. Any exceptions are stated on your Cost Sharing Schedule.

**Inpatient Coinsurance** applies only to Inpatient hospital care. It applies to any Inpatient admission to a Short Term General Hospital, Skilled Nursing Facility, Physical Rehabilitation Facility or an eligible facility for Behavioral Health Care. Inpatient facility and professional fees are subject to this Coinsurance.

A separate Coinsurance may apply to durable medical equipment, medical supplies and prosthetics, as described in Section 7 “Covered Services,” IV “Durable Medical Equipment, Medical Supplies and Prosthetics.” If your Group has purchased a Pharmacy Rider, a separate Coinsurance may apply to pharmacy purchases. These Coinsurance amounts are shown on your Cost Sharing Schedule and do not count toward meeting any other Coinsurance limit.
IV. Deductible and Coinsurance Maximums

Depending on the cost sharing plan chosen by your Group, the following cost sharing limits apply, as shown on your Cost Sharing Schedule:

A. When a Member’s Deductible is met, no further Deductible is required for that Member for the remainder of the Calendar Year. When a family Deductible is met, no further Deductible is required for the family for the remainder of the Calendar Year. No one Member may contribute more than his or her individual Deductible toward meeting the family Deductible.

B. When a Member’s Coinsurance Maximum is met, no further Coinsurance is required for that Member for the remainder of the Calendar Contract Year. When a family Coinsurance Maximum is met, no further Coinsurance is required for the family for the remainder of the Calendar Year. No one Member may contribute more than his or her individual Coinsurance Maximum toward meeting the family Coinsurance Maximum.

C. A separate Deductible and Coinsurance may apply to durable medical equipment; medical supplies and prosthetics covered under Section 7 “Covered Services,” IV “Durable Medical Equipment, Medical Supplies and Prosthetics.” If your Group has purchased a Pharmacy Rider, separate Deductible and Coinsurance may apply to pharmacy purchases. These amounts are shown on your Cost Sharing Schedule and do not count toward meeting any other Deductible or Coinsurance maximums.

Deductible amounts are limited to the Maximum Allowable Benefit. Coinsurance is a percentage of the Maximum Allowable Benefit. Amounts that exceed the Maximum Allowable Benefit do not count toward your Deductible or Coinsurance requirements or maximums. Copayments and the cost of noncovered services or Penalties do not count toward any Deductible or Coinsurance requirements or maximums.

V. Other Out-of-Pocket Costs

In addition to the cost sharing amounts shown on your Cost Sharing Schedule, you are responsible for paying other costs, as follows:

A. Certain annual coverage limitations may apply under this plan. Annual coverage limitations apply to certain Covered Services, as stated on your Cost Sharing Schedule and in this Certificate. You are responsible for the cost of services that exceed an annual limitation.

B. Amounts That Exceed the Maximum Allowable Benefit. Benefits under this plan are limited to the Maximum Allowable Benefit. “Maximum Allowable Benefit” means the dollar amount available for a specific Covered Service. The Maximum Allowable Benefit is determined as stated in Section 14 “Definitions.” As stated in this Certificate and your riders, endorsements or amendments, you may be responsible for paying the difference between the Maximum Allowable Benefit and the charge.

C. Noncovered or Excluded Services. You are responsible for paying the full cost of any service that is not described as a Covered Service in this Certificate. You are responsible for paying the full cost of any service that is excluded from coverage in this Certificate. This applies even if a physician or other Designated Provider prescribes, orders or furnishes the service and even if the services meets Anthem’s definition of Medical Necessity.
SECTION 3: ACCESS TO CARE THROUGH YOUR PRIMARY CARE PROVIDER (PCP)

Please see Section 14, “Definitions” for definitions of specially capitalized words.

I. The Important Role of Your PCP

Your Primary Care Provider (PCP) is a physician who becomes familiar with your medical history and coordinates your access to other health care services. Always talk to your PCP before you receive health care services unless it is not possible or safe to delay receipt of care until you can contact your PCP for direction. Your PCP will either furnish your care or authorize a Referral to another provider. Benefits will be denied if you do not obtain your PCP’s Referral in advance as required. Exceptions are stated in Section 4 “Open Access to Care.”

II. Selecting a PCP

Each Member must select a PCP. The choice of PCP should be made at enrollment time. Different family members may have different health care needs. Therefore, each Member may select a different PCP. For example, you may choose a general practitioner PCP who is near your workplace. But for your child, you may choose a pediatrician PCP who is near your home. Indicate each family Member’s PCP on your enrollment form.

Anthem provides directories that list PCP choices. Printed directories are updated periodically. Therefore, your directory book may not always be current at the time you need to select a PCP. For the most up-to-date information about PCPs, please visit Anthem’s website, www.anthem.com. Or, you may contact Customer Service for assistance. The toll-free telephone number is 1-800-870-3057.

PCP Selection for Newborns - You should choose your newborn’s PCP before your due date. You can notify Anthem of the selection by sending a completed enrollment form as soon as possible after your baby is born.

Changing a PCP - PCP changes can be made by calling Anthem’s Center or by writing to Anthem at the address listed in the Welcome Page of this Certificate. The change will become effective on the day we receive your call or letter. If you request a later effective date, we will honor your request. You can change your PCP for any reason. Anthem may inquire about your reason for changing a PCP because your information helps us to maintain the quality of the Network.

III. Referrals From Your PCP to a Specialist

Always talk to your PCP before you seek health care services. If your PCP determines that you need services at a hospital or from a specialist (such as a surgeon, physical therapist or cardiologist), your PCP will write a Referral for the care. A Referral is your PCP’s written approval for Covered Services. It describes the specific services and the number of visits or treatments that are approved. No Benefits are available for specialized care unless you obtain your PCP’s Referral in advance. No Benefits are available for services that exceed the limits of your PCP’s Referral. Please see Section 4 “Open Access to Care,” for exceptions to PCP Referral requirements.

IV. Plan Approval for Specialized Care

In addition to your PCP’s Referral, Anthem must approve certain Covered Services before you receive them. This approval is called “Precertification.”

- Network Services – With few exceptions, your PCP will Refer you to a Network Provider for your specialized care. Your PCP or Network Provider will obtain any required Precertification from Anthem for Network Services.
- **Out-of-Network Services** - In limited instances, your PCP or Network Provider may determine that your care cannot be furnished in the Network and that it is necessary for you to receive care from an Out-of-Network Provider. **Benefits are available for Out-of-Network Services only when the services are approved in advance by your PCP’s Referral and in advance by Anthem.** Your PCP is responsible for writing a Referral and for contacting Anthem for Precertification. No Benefits will be available if you do not obtain your PCP’s Referral before you receive Out-of-Network Services.

If Anthem notifies you that Out-of-Network Services are not approved, and you decide to receive the services, no Benefits will be available and you will be responsible for the full cost of the care. No Benefits are available for care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services.

**Except for Emergency Care as described in Section 6 “Urgent and Emergency Care,” you must contact your PCP to obtain a Referral before you receive Out-of-Network Services, even if you are temporarily outside the Service Area for a definite period of time (such as students, vacationers and business travelers).** Your PCP will contact Anthem for any required Precertification of the Out-of-Network Care. No Benefits will be Precertified or available for elective Inpatient or Outpatient care that can be safely delayed until you return to the Service Area or for care that a reasonable person would anticipate before leaving the Service Area. No Benefits are available for routine medical exams, immunizations, routine gynecological exams, diagnostic tests related to routine care, other preventive care or any other care that can be safely delayed until you return to the Service Area for Network Services. School infirmary facility or infirmary room charges are not covered under any portion of this Certificate.

Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including Copayment, Deductible, and Coinsurance, requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

Please see Section 7 “Covered Services,” V, “Behavioral Health Care” for complete information about Preauthorization of Out-of-Network Services for Mental Disorders and Substance Abuse Conditions.
SECTION 4: OPEN ACCESS TO CARE

Please see Section 14, “Definitions” for definitions of specially capitalized words.

As explained in Section 3 “Access to Care Through Your Primary Care Provider (PCP),” Benefits are available for Covered Services if your PCP provides your care or approves your care by writing a Referral in advance. However, you do not need to obtain your PCP’s Referral to be covered for the services described in this Section. Please read this Section carefully, as other limitations may apply.

I. Routine Vision Exam

Members may receive a routine vision exam from any Optometrist or Ophthalmologist in the Network. A PCP Referral is not required. Benefits may be limited as shown on your Cost Sharing Schedule. No Benefits are available for Out-of-Network Services. Please see part II of your Cost Sharing Schedule, “Preventive Care” for other important limitations.

Please note: Care related to eye disease or injury is not routine vision care. Such care must be furnished or approved in advance by your PCP, as stated in Section 7 “Covered Services,” VI “Important Information about Other Covered Services,” H “Vision Services.”

II. Emergency Care

In an emergency, it may not be possible or safe to delay treatment. A PCP Referral is not required for Emergency Care in a hospital emergency facility. Please see Section 6 “Urgent and Emergency Care” for important guidelines.

III. Visits to a Network Urgent Care Facility

A PCP Referral is not required for visits to a Network Urgent Care Facility for urgent health care services. Please see Section 6, “Urgent and Emergency Care” for more information about urgent care.

IV. Visits to a Network Walk-In Center

A PCP Referral is not required for visits to a Network Provider at a Network Walk-In Center for diagnosis, care or treatment of an illness or injury.

V. Emergency Ambulance Services

A PCP Referral is not required for emergency ambulance transportation. Please see Section 7 “Covered Services,” II “Ambulance Services,” for complete information.

VI. Behavioral Health Care

A PCP Referral is not required for Behavioral Health Care. However, your care must be furnished by a Network Behavioral Health Provider, except as stated in Section 7 “Covered Services,” V “Behavioral Health Care.” Benefits may be limited as shown on your Cost Sharing Schedule.

VII. Certain Dental Services

Certain “Dental Services” described in Section 7 “Covered Services,” VI “Important Information About Other Covered Services” do not require a PCP Referral. However, you must receive services from a Network Provider.
VIII. Obstetrical and Gynecological Care

Obstetrical and Gynecological Care – PCP Referrals are not required for obstetrical or gynecological care provided that you receive care from a Network Obstetrician/Gynecologists, Network Advanced Practice Registered Nurse (APRN) obstetrician/gynecologists or Network New Hampshire Certified Midwives (NHCM). Subject to the terms and limitations stated in Section 7 “Covered Services,” II “Outpatient Services,” B, 5, “Maternity care,” examples of network obstetrical or gynecological care include:

- Pregnancy tests, routine maternity care (including prenatal care, delivery and postpartum services), care for high risk pregnancies, complications of pregnancy, and care related to postpartum complications,
- An annual gynecological visit (including related laboratory and radiological tests), mammograms or the treatment of endometriosis,
- Follow-up care for obstetrical or gynecological conditions identified in the course of a pregnancy or as a result of an annual gynecological visit,
- Laboratory and x-ray tests and Inpatient admissions ordered by a Network Obstetrician/Gynecologist, Network APRN or Network NHCM for an obstetrical/gynecological condition.

Important notes: Your PCP must furnish the following kinds of care or approve the care in advance, as stated in Section 3 “Access To Care Through Your Primary Care Provider (PCP).” Otherwise, no Benefits are available for these services:

- Care for general medical conditions. Examples of general medical conditions are: breast or cervical cancer, hemorrhoids (even if related to pregnancy), high blood pressure, diabetes, blood disorders, kidney disorders or digestive tract disorders.
- Obstetrical or gynecological care furnished by a Network Provider (such as a family practitioner or urologist) other than a Network Provider who specializes in obstetrical/gynecological care.
- Any Out-of-Network care must be approved in advance by your PCP and by Anthem, as explained in Section 3, “Access to Care Through Your Primary Care Provider (PCP).”

IX. Chiropractic Care

A PCP Referral is not required when you receive Covered Services from any Network Chiropractor. No Benefits are available for Out-of-Network Services. Please see Section 7 “Covered Services,” III “Chiropractic Care,” for a complete description of Benefits, limitations and exclusions.

X. Diabetes Management Programs

PCP Referrals are not required for diabetes management programs. However, Covered Services must be furnished by a Network Diabetes Education Provider. Otherwise, no Benefits are available for diabetes management programs. Please see Section 7 “Covered Services,” II “Outpatient Services,” A “Diabetes Management Programs,” for complete information.
SECTION 5: ABOUT MANAGED CARE

Please see Section 14, “Definitions” for definitions of specially capitalized words.

This is a Managed Health Care plan. This means that when you receive certain Covered Services, Anthem (or a designated administrator) works with you and your health care providers to determine that your Covered Services are Medically Necessary. The definition of Medical Necessity is stated in Section 14 “Definitions.”

A Member’s right to Benefits for Covered Services provided under this Certificate is subject to certain health care management policies or guidelines and limitations, including, but not limited to, Anthem’s medical policy and guidelines for Precertification (including Anthem’s Concurrent Review process). Health care management guidelines, their purposes, requirements and effects on Benefits, are described in this Section and throughout this Certificate. Failure to follow the health care management guidelines and procedures for obtaining Covered Services will result in reduction or denial of Benefits, as stated in this Certificate and any riders, endorsements or amendments that are part of this Certificate.

“Precertification” is the process used by Anthem to review services proposed by your Designated Provider to determine if the service meets Anthem’s definition of Medical Necessity, as stated in Section 14 “Definitions.” Your provider’s orders and/or Anthem’s Precertification does not guarantee coverage for or the payment of the service or procedure reviewed. Benefits are subject to all of the terms and conditions of this Certificate including Copayment, Deductible, and Coinsurance, requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

I. Your Role

You play an important role in this managed health care plan. As a Member, you should become familiar with and follow plan rules. These are described in Sections 1 through 6. Knowing and following plan rules is the best way for you to enjoy all of the advantages of this coverage. For example, Section 3 “Access to Care Through Your Primary Care Provider (PCP),” explains that you need to select a PCP and you need to contact your PCP before you receive health care services. Please remember that you are responsible for obtaining your PCP’s written Referral before you receive Out-of-Network Services.

Your suggestions about improving the plan are important to Anthem. Please contact Customer Service to let Anthem know about your suggestions. The toll-free telephone number is 1-800-870-3057. You can appeal any decision made by Anthem about your coverage. Please see Section 11 “Member Satisfaction Services and Appeal Procedure,” for information about how to inform Anthem about your suggestions or to use the appeal procedure.

II. The Role of Network Providers

Your PCP and other Network Providers work together to make sure that you have access to the health care services that you need. Your PCP is responsible to oversee and coordinate your health care services.

Most often, your PCP will provide your routine or urgent care directly. If your PCP determines that you require specialized care that falls outside his or her clinical expertise or services offered, your PCP will refer you to another provider. The Referral will be in writing or will be completed by other notification methods prescribed by Anthem for use by PCPs. Your PCP may specify the type of service and number of visits or treatments that are approved for a specified period of time. With few exceptions, you will be referred to a provider in the Network. Network Providers are expected to keep your PCP informed about their recommendations and findings and the treatment you require. Your PCP and Network Providers work together to arrange for any visits or treatments that are required in addition to those approved under the original PCP Referral.
Your PCP or Network Provider will contact Anthem as appropriate for any required Precertification for your Network Services. For example, if your PCP or Network Provider admits you to a hospital for Inpatient care, your PCP or Network Provider will let Anthem know about the Referral and will provide Anthem with any clinical information that may be required to review the Referral. Your PCP will also contact Anthem to provide the clinical information required to review a Referral to an Out-of-Network Provider.

III. The Role of Anthem

As the administrator of Benefits under this health plan, Anthem’s Medical Director and Medical Management division play an important role in the management of your Benefits. Some examples are:

A. **Referral review and Precertification** - Anthem requires that Network Providers must obtain Precertification before you receive Inpatient care and before you receive certain Outpatient services. Precertification of any Referral for Out-of-Network Services is required by Anthem. Emergency admissions must be reported to Anthem within 48 hours so that Anthem can conduct a Precertification review. If you have any questions regarding Managed Care guidelines or to determine which services require Precertification, please call Customer Service for assistance. The toll-free telephone number is **1-800-870-3057**. Or, you may refer to Anthem’s website at: [www.anthem.com](http://www.anthem.com).

“Precertification” refers to the process used by Anthem to review your health care services to determine if a service is Medically Necessary and is delivered in the most appropriate health care setting. Precertification does not guarantee coverage for or the payment of the service or procedure reviewed. Benefits are subject to all of the terms and conditions of this Certificate including Copayment, Deductible, and Coinsurance, requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

Whenever Anthem reviews a PCP’s Referral or any Precertification request, the appropriate Medical Director may discuss the services with your PCP or Network Provider or with another provider and may ask for medical information about you and the proposed services. A Medical Director may determine that Benefits are available only if you receive services from a Network Provider, a Contracting Provider or from a Designated Provider that is, in the opinion of the Medical Director, most appropriate for your care. The decision to receive or decline to receive health care services is your sole responsibility, regardless of the decision made regarding reimbursement.

B. **Prior Approval.** At your physician’s request, Anthem will review proposed services to determine if the service is a Covered Service that meets Anthem’s definition of Medical Necessity as stated in Section 14 “Definitions.” For example, if your physician proposes Outpatient surgery that may be considered a noncovered cosmetic or dental procedure, he or she may submit clinical information for review before you receive the service. To make coverage determinations, Anthem refers to managed care guidelines, internal policies including, but not limited to medical policies and the terms of this Certificate. The prior approval process does not satisfy Precertification requirements. If your proposed service requires Precertification, please refer to Section 3 “Access to Care Through Your Primary Care Provider (PCP),” for complete information.

C. **Determinations about Medical Necessity.** Anthem makes determinations about Medical Necessity based on the definition found in Section 14. Anthem’s medical policy assists in Anthem’s determinations regarding Medical Necessity and other related issues. Anthem’s medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. For complete information, please see Section 11 “Member Satisfaction Services and Appeal Procedure.”
D. **Determinations about Experimental/Investigational Services.** Anthem reviews services that may be Experimental/Investigational based on the terms of Section 8 “Limitations and Exclusions,” II “Exclusions,” “Experimental/Investigational Services.”

Anthem’s medical policy assists in Anthem’s review regarding Experimental/Investigational Services and other issues. Anthem’s medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Experimental/Investigational Services. For complete information, please see Section 11 “Member Satisfaction Services and Appeal Procedure.”

E. **Review of New Technologies.** Medical technology is constantly changing and Anthem reviews and updates medical policy periodically regarding coverage for new technologies. Anthem evaluates new medical technologies to define medical effectiveness and to determine appropriate coverage. Anthem’s evaluations are focused on the following factors:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve net health outcomes.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the Investigational setting.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding coverage for new technologies. For complete information, please see Section 11 “Member Satisfaction Services and Appeal Procedure.”

F. **Case Management** means Anthem’s process of evaluating and arranging for Medically Necessary treatment for Members identified as being eligible for individual Case Management through the use of one or more managed care programs.

Case Management is a program tailored to the Member. Anthem’s case managers work collaboratively with the Member, the Member’s family and providers to coordinate the Member’s health care Benefits. In certain extraordinary circumstances involving intensive Case Management, Anthem may, at its discretion, provide Benefits for care that is Medically Necessary but not listed as a Covered Service in this Certificate. Or, Anthem may provide Benefits for Medically Necessary services that supplement the Covered Services described in this Certificate. Anthem may extend Benefits for Covered Services beyond the Benefit maximums stated in this Certificate. Anthem makes decisions regarding Case Management on a case-by-case basis. By providing services through Case Management, Anthem makes exceptions only for a specific case and is not committed to providing similar coverage and Benefits again for you, nor for other Members. All other terms and conditions of this Certificate shall be strictly administered by Anthem.

Anthem has the right to alter or discontinue Case Management when it is no longer Medically Necessary. The Member or the Member’s representative shall be notified in writing of alterations or a discontinuation of Case Management. Members who disagree with Anthem’s determination may utilize the appeal procedure described in Section 11 “Member Satisfaction Services and Appeal Procedure.”
V. Important notes about this Section

*Your PCP’s Referral, Designated Provider’s orders, Anthem’s Precertification or Prior Approval does not guarantee Benefits.* Benefits are subject to all of the terms and conditions of this Certificate including Copayment, Deductible, and Coinsurance, requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

Anthem’s Medical Director or Medical Management division takes into consideration the recommendations of the Member’s physician and clinical information when making decisions about Precertification requests, Prior Approval requests, Medical Necessity, Experimental/Investigational Services and new technologies. When appropriate to review a proposed service, Anthem’s Medical Director or Medical Management division considers published peer-review medical literature about the service, including the opinion of experts in the relevant specialty. At times, Anthem may consult with experts in the specialty. Anthem may also review determinations or recommendations of nationally recognized public and private organizations that review the medical effectiveness of health care services and technology.
SECTION 6: URGENT AND EMERGENCY CARE

Please see Section 14, “Definitions” for definitions of specially capitalized words.

I. Urgent Care

Whenever possible, contact your PCP or Network obstetrical/gynecological specialist for direction before you receive urgent medical care. Examples of conditions that may require urgent care are: sprain, sore throat, rash, earache, minor wound, moderate fever or abdominal or muscle pain.

Please note: You will have lower out-of-pocket expenses if you to seek urgent care from your PCP or Network obstetrical/gynecological specialist as an alternative to a hospital emergency room visit. If it is not possible or safe for you to delay care until you can visit your PCP or Network obstetrical/gynecological specialist, you will have lower out-of-pocket expenses if you visit a Network Provider at a Network Walk-In Center or you visit a Network Urgent Care Facility as an alternative to a hospital emergency room visit. Please see page 1 of your Cost Sharing Schedule to compare Copayments for office visits, Walk-In Centers, Urgent Care Facilities and emergency rooms.

You do not need to obtain your PCP’s Referral before you visit a Network Walk-In Center or Network Urgent Care Facility for urgent care.

II. Emergency Care

It may not always be possible or safe to delay treatment long enough to consult with your PCP or Anthem before you seek care. In an emergency, go to the nearest emergency facility immediately for Emergency Care. Call 911 for assistance if necessary.

Emergency Care means Covered Services you receive due to the sudden onset of a serious condition. A serious condition is a medical, psychological or substance abuse condition that manifests itself by symptoms of such severity that you need immediate medical attention to prevent any of the following:

- Serious jeopardy to your health,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Examples of conditions or symptoms that may require Emergency Care are: suspected heart attack or stroke, a broken bone, uncontrolled bleeding, unconsciousness (including as a result of drug overdose or alcohol poisoning) or you are at serious risk of harming yourself or another person.

III. Emergency Room Visits for Emergency Care

Benefits are available for Emergency Care in any licensed hospital emergency room, provided that at least one of the following criteria is met:

- Your condition meets the definition of “Emergency Care” as stated in II (above), or
- The symptoms that caused you to seek care in a hospital emergency room would be judged by a reasonable person to require Emergency Care as defined in II (above), or
- You obtain your PCP’s Referral or approval from your Network obstetrical/gynecological specialist in advance.
No approval given by Anthem or a Network Provider for Emergency Care will be rescinded or modified after the care is furnished, provided that your coverage is in effect on the date you receive the care.

Your share of the cost for use of the emergency room is shown on your Cost Sharing Schedule. Any Emergency Room Copayment will be waived if you are admitted to the hospital as a bed patient (Inpatient) directly from the emergency room. Depending on the plan chosen by your Group, certain services furnished in a hospital emergency room may be subject to Deductible and Coinsurance in addition to the emergency room Copayment. Any applicable Deductible and Coinsurance are not waived if you are admitted to the hospital as a bed patient from the emergency room. Please see, “Emergency Room Visits for Emergency Care” on page 3 of your Cost Sharing Schedule to determine your Deductible and/or Coinsurance for emergency room services such as, but not limited to: the physician’s fee, surgery, diagnostic tests, medical supplies and drugs.

Please note: You will have lower out-of-pocket expenses if you seek urgent care from your PCP or Network obstetrical/gynecological specialist as an alternative to a hospital emergency room visit. If it is not possible or safe for you to delay care until you can visit your PCP or Network obstetrical/gynecological specialist, you will have lower out-of-pocket expenses if you visit a Network Provider at a Network Walk-In Center or you visit a Network Urgent Care Facility as an alternative to a hospital emergency room visit. Please see page 1 of your Cost Sharing Schedule to compare Copayments for office visits, Walk-In Centers, Urgent Care Facilities and emergency rooms.

You do not need to obtain your PCP’s Referral before you visit a licensed hospital emergency room for Emergency Care or a Network Walk-In Center or Network Urgent Care Facility for urgent care.

### IV. Inpatient Admissions to a Hospital for Emergency Care

Your share of the cost for “Inpatient Services” is shown on part I of your Cost Sharing Schedule.

**A. Medical/surgical admissions for Emergency Care** - Benefits are available for an Inpatient admission for medical/surgical Emergency Care, provided that Inpatient care is Medically Necessary and your condition meets the definition of “Emergency Care” as stated in II (above).

If it is not safe or possible to delay care until you can obtain a Referral in advance from your PCP or from the Network Provider who furnishes your maternity care, you (or someone acting for you) must do one of the following:

- Notify your PCP or the Network Provider who furnishes your maternity care after you are admitted, or
- Notify Anthem after you are admitted by calling 1-800-531-4450.

**Notice to your PCP, Network Provider or to Anthem must be made within 48 hours after you are admitted or on the next business day after you are admitted, whichever is later.**

If you fail to make notice as required and Anthem later determines that the care was not Emergency Care (as defined in II above), did not meet the definition of Medical Necessity stated in Section 14 or was otherwise a noncovered service, no Benefits will be available and you will be responsible for the full cost of the care.

If you are unable to call within 48 hours, Anthem’s Medical Director will determine if your circumstances prevented timely notification. Anthem determines whether or not Emergency Care conditions are met by reviewing your admission records.

Please see Section 3 “Access to Care Through Your Primary Care Provider (PCP)” for information about access to planned or scheduled Network Services and Out-of-Network Services. Please remember that Out-of-Network Services must be approved in advance by your PCP and by Anthem. Otherwise, no Benefits are available for the Out-of-Network Services.
Important Note: You do not need to contact Anthem or your PCP within 48 hours of a maternity admission, provided that your prenatal care is furnished by a Network Provider who specializes in maternity care and you are admitted to a hospital in the Network. Out-of-Network prenatal care must be authorized in advance by your PCP's Referral and Anthem's Precertification. Otherwise, no Benefits are available for the prenatal care or for the maternity admission. Please see Section 3 “Access to Care Through Your Primary Care Provider (PCP)” for complete information about access to Out-of-Network Services.

B. Behavioral Health admissions for Emergency Care. Benefits are available for Inpatient admissions for Behavioral Health Emergency Care, provided that Inpatient care is Medically Necessary and your condition meets the definition of “Emergency Care” as stated in II (above).

If you are admitted to a hospital as a bed patient for Inpatient Emergency Behavioral Health Care, you (or someone acting for you) must contact Anthem for Preauthorization within 48 hours (or on the next business day, whichever is later). Please call 1-800-228-5975 for Preauthorization.

If you fail to make notice as required and Anthem later determines that the care was not Emergency Care as defined in II above, did not meet the definition of Medical Necessity stated in Section 14 or was otherwise a noncovered service, no Benefits will be available and you will be responsible for the full cost of the care.

If you are unable to call within 48 hours, Anthem will determine if your circumstances prevented timely notification. Anthem determines whether or not Emergency Care conditions are met by reviewing your admission records.

V. Limitations

In addition to the limitations and exclusions listed in Section 7 “Covered Services,” VI “Important Information About Other Covered Services,” and in Section 8 “Limitations and Exclusions,” the following limitations apply specifically to Emergency Care:

A. “Follow-up” care is any related Covered Service that you receive after your initial emergency room visit, or Walk-In Center visit or Urgent Care Facility visit. To be eligible for medical care Benefits, your follow-up care must be furnished by your PCP, authorized in advance by your PCP’s Referral or furnished by a Network Provider who specializes in obstetrical/gynecological care. Otherwise, no Benefits are available for the follow-up care.

For Mental Disorders or Substance Abuse Conditions, the plan rules stated in Section 7 “Covered Services,” V “Behavioral Health Care,” apply to follow-up care.

B. When determining whether or not your services meet the definition of Emergency Care in this Section, Anthem will consider not only the outcome of your Outpatient visit or Inpatient admission, but also the symptoms that caused you to seek the care. To make this determination, Anthem reserves the right to review medical records after you have received your services.

C. Emergency Care and urgent care do not include routine care. Routine care includes routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, immunizations or preventive care. Emergency Care and urgent care do not include any service related to or resulting from routine care.

D. Emergency Care and urgent care do not include elective care. Elective care is care that can be delayed until you can contact your PCP, Network obstetrical/gynecological specialist or Anthem, for direction in advance. Examples of elective care are: scheduled Inpatient admissions or scheduled Outpatient care. Emergency Care and urgent care do not include any service related to or resulting from elective care.
E. Complications of noncovered services. No Benefits are available for care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services, even if the care meets Anthem’s definitions of Emergency Care, urgent care and/or Medical Necessity.

F. If you are admitted as a bed-patient to an Out-of-Network Hospital for Emergency Care, eligible Benefits are provided only until Anthem and your PCP determine that your condition permits your transfer to a Network Hospital. The mode of transportation will be selected by Anthem and the cost of the selected transportation will be covered.
SECTION 7: COVERED SERVICES

Please see Section 14, “Definitions” for definitions of specially capitalized words.

This Section describes Covered Services for which Anthem provides Benefits. All Covered Services must be prescribed or furnished by a Designated Provider according to the plan guidelines stated in this Certificate. Preventive Care services are listed in subsection II, A “Preventive Care,” (below). All other Covered Services must be Medically Necessary for the diagnosis and treatment of disease, illness, injury, or for maternity care. Otherwise, no Benefits are available. The Covered Services described in this Section are available for treatment of the diseases and ailments caused by obesity and morbid obesity, as required by New Hampshire law.

Please remember the plan guidelines explained in Sections 1 through 6. Some important reminders are:

- Members are entitled to the Covered Services described in this Section. All Benefits are subject to the exclusions, conditions and limitations, terms and provisions described in Section 8, “Limitations and Exclusions,” and elsewhere in this Certificate and any amendments to this Certificate.
- To receive maximum Benefits for Covered Services, you must follow the terms of the Certificate, including, when applicable, receipt of care from your PCP, use of Network Providers, and obtaining any required Precertification.
- Benefits for Covered Services are based on the Maximum Allowable Benefit for such services. Deductible amounts are limited to the Maximum Allowable Benefit. Coinsurance is a percentage of the Maximum Allowable Benefit. No Benefits are available for amounts that exceed Anthem’s Maximum Allowable Benefit.
- Anthem’s payment for Covered Services will be limited by any Copayment, Deductible, Coinsurance or annual or lifetime Benefit limit applicable to your plan. Such limitations are stated on your Cost Sharing Schedule, this Certificate and in any amendments to this Certificate.
- Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Certificate.
- 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.
- Anthem makes determinations about Referrals, Precertification, Medical Necessity, Experimental / Investigational Services and new technology based on the terms of this Certificate, including the definition of Medical Necessity. The definition of Medical Necessity is stated in Section 14. Anthem’s medical policy assists in Anthem’s determinations. Anthem’s medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. For complete information, please see Section 11 “Member Satisfaction Services and Appeal Procedure.”

Please note:
This Section often refers to your Cost Sharing Schedule. Your cost sharing amounts and important limitations are shown on the Cost Sharing Schedule.

With few exceptions, Benefits are available only when your PCP furnishes Covered Services or approves the services in advance by authorizing a Referral. Exceptions are stated in Section 4 “Open Access to Care.” Otherwise, no Benefits are available.
Out-of-Network care must be approved by your PCP and by Anthem in advance. If Anthem notifies you that Out-of-Network services are not approved and you decide to receive the services, no Benefits will be available. You will be responsible for the full cost of the care.

I. Inpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Inpatient medical/surgical admissions. This includes maternity admissions. Coverage includes the following:

A. Care in a Short Term General Hospital - semi-private room and board, nursing care, pharmacy services and supplies, laboratory and x-ray tests, operating room charges, delivery room and nursery charges, physical, occupational and speech therapy typically provided in a Short Term General Hospital while you are a bed patient (Inpatient). Custodial Care is not covered. Please see Section 8 “Limitations and Exclusions,” II “Exclusions,” for a definition of “Custodial Care.”

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours except when authorization is required for use of certain providers or facilities, or to reduce your out-of-pocket costs.

Also, under federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

B. Care in a Skilled Nursing Facility or Physical Rehabilitation Facility - semi-private room and board, nursing and ancillary services typically provided in a Skilled Nursing or Physical Rehabilitation Facility while you are a bed patient (Inpatient). Benefits may be limited as shown on your Cost Sharing Schedule. When counting the number of Inpatient days, the day of admission is counted but the day of discharge is not. Custodial Care is not covered. Please see Section 8 “Limitations and Exclusions,” II “Exclusions,” for a definition of “Custodial Care.”

C. Inpatient Physician and Professional Services - physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests. Benefits for Inpatient medical care are limited to daily care furnished by the attending physician, unless another physician’s services are Medically Necessary, as determined by your PCP and Anthem. For Skilled Nursing or Physical Rehabilitation Facility admissions, Benefits may be limited, as shown on your Cost Sharing Schedule. Custodial Care is not covered. Please see Section 8 “Limitations and Exclusions,” II “Exclusions,” for a definition of “Custodial Care.”

Please see subsection V, “Behavioral Health Care (Mental Health and Substance Abuse Care)” and subsection VI, “Important Information about Other Covered Services” for related information about Inpatient services. Also, see Section 8 for important “Limitations and Exclusions” that may apply to Inpatient Services.

II. Outpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Outpatient medical/surgical care. Coverage includes the following:

A. Preventive Care. In general, the term “Preventive Care” under this Certificate refers to medical care for adults and children with no current symptoms or prior history of a medical condition associated with the care. For
Members who have current symptoms or have been diagnosed with a medical condition, services associated with the symptoms or diagnoses are not Preventive Care. Some exceptions to this definition are listed in this subsection but otherwise, services for the diagnosis or treatment of an illness, injury or medical condition are covered under other applicable sections of this Certificate. Whether or not a service is Preventive Care, Covered Services are subject to the cost sharing requirements specified on your Cost Sharing Schedule. For the purposes of this subsection, Preventive Care services are:

1. Immunizations for babies, children and adults (including travel and rabies immunizations),
2. Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening,
3. Routine physical exams for babies, children and adults (including one annual gynecological exam),
4. Family planning visits, such as medical exams related to family planning and genetic counseling. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, or contraceptive injections.

Please note that prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are not covered under this Certificate. If your Group has purchased a Pharmacy Rider, please see your rider for information about coverage for prescription contraceptive drugs and devices.

No Benefits are available for services related to the use of nonprescription contraceptives. Examples of noncovered services are: contraceptive creams and foams, condoms, spermicidal jelly or contraceptive sponges.

Please see subsection VI, C for information about “Infertility Diagnostic Services”

5. Nutrition counseling by a Network Nutrition Counselor practicing independently or as part of a physician practice or an Outpatient hospital clinic. Out-of-Network nutrition counseling is not covered. Benefits may be limited as shown on your Cost Sharing Schedule.

Benefits are available for weight management counseling provided during covered nutrition counseling visits or as part of a covered diabetes management program (see 8, “diabetes management programs” below). No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Certificate. However, Benefits are available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see subsection VI, G, 4, “Surgery for conditions caused by obesity.”

No Benefits are available for weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

6. Routine vision exams to determine the need for vision correction. The exam must be furnished by an Optometrist or Ophthalmologist in the Network. Otherwise, no Benefits are available. Benefits may be limited, as shown on your Cost Sharing Schedule. Please see subsection VI, H, “Vision Services” for information about services for eye disease or injury.

7. Routine hearing exams to determine the need for hearing correction. Benefits may be limited, as shown on Your Cost Sharing Schedule. Please see subsection VI, B, “Hearing Services” for information about services for ear disease or injury.
8. Diabetes Management Programs. You do not need a Referral from your PCP to be eligible for Benefits. However, Covered Services must be ordered by a physician and furnished by a Network Diabetes Education Provider. No Benefits are available for Out-of-Network Services. Covered Services include:

- Individual counseling visits,
- Group education programs and fees required to enroll in an approved group education program, and
- External insulin pump education is covered for Members whose external insulin pump has been approved by Anthem. The Diabetes Education Provider must be pump-certified. Please see subsection IV, E, “Durable Medical Equipment, Medical Supplies and Prosthetics” for information about coverage for external insulin pumps.

For information about diabetes education programs or Network Diabetes Education Providers, visit Anthem’s website at www.anthem.com or call Anthem’s Customer Service Center for assistance. The toll-free telephone number is 1-800-870-3057.

In addition to the limitations and exclusions listed in Section 8 of this Certificate, the following limitations apply specifically to diabetes management services:

- No Benefits are available for services furnished by a provider who is not a Network Diabetes Education Provider.
- Insulin, diabetic medications, blood glucose monitors, external insulin pumps and diabetic supplies are not covered under this subsection. Please see subsection IV, E, “Durable Medical Equipment, Medical Supplies and Prosthetics” for information about diabetic supplies. If your Group has purchased a Pharmacy Rider, insulin, diabetic medications and diabetic supplies are also covered according to the terms of the rider when Covered Services are purchased at a pharmacy.

Benefits are available for weight management counseling provided as part of a covered diabetes management program or during covered nutrition counseling visits (see 5 above). No other non-surgical service, treatment, procedure or program for weight or appetite control, weight loss, weight management or control of obesity is covered under this Certificate. However, Benefits are available for Medically Necessary Covered Services furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see subsection VI, G, 4, “Surgery for conditions caused by obesity.”

No Benefits are available for weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

B. Medical/Surgical Care furnished in a Physician’s Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider or Independent Radiology Provider (in addition to the Preventive Care above). In addition to Preventive Care commonly provided in a physician’s office (see A, above), the following services are covered:

1. Medical exams, consultations, surgery and anesthesia, injections (including allergy injections), medical treatments (including allergy treatments and radiation treatments),

2. Laboratory and x-ray tests (including allergy testing and ultrasound),
3. CT Scan, MRI, chemotherapy, infusion therapy,

4. Medical supplies and drugs administered during the visit. Benefits are available for covered prescription medications, injectable drugs, radioactive materials, dressings and casts administered or applied during a medical care visit for the prevention of disease, illness or injury or for therapeutic purposes. No Benefits are available for fertility hormones or fertility drugs.

Hormones, insulin and prescription drugs are not covered under any portion of this Certificate when purchased in an Outpatient setting for use outside the setting. If your Group has purchased a Pharmacy Rider, please see your rider for coverage information. Medical equipment, supplies and prosthetics purchased in an Outpatient setting for use outside the setting are not covered under this subsection. Please see subsection IV, E “Durable Medical Equipment, Medical Supplies and Prosthetics” for coverage information.

5. Maternity care. Total maternity care includes the provider’s fees for prenatal visits, delivery, Inpatient medical care and postpartum visits. Most often, your provider bills all of these fees together in one charge for delivery of a baby and the Benefit includes all of the services combined. The Benefit is available according to the coverage in effect on the date of delivery. Note: If a provider furnishes only prenatal care or the delivery, or postpartum care, Benefits are available according to the coverage in effect on the date you receive the care.

Covered Services may be furnished by a Network Obstetrician/Gynecologist, a Network Advanced Practice Registered Nurse (APRN) obstetrician/gynecologist or a Network New Hampshire Certified Midwife (NHCM). A Referral from your PCP to a Network Obstetrician/Gynecologist or Network APRN or Network NHCM is not required.

Benefits are available for routine maternity care furnished by a Network New Hampshire Certified Midwife (NHCM), provided that the Network NHCM is certified under New Hampshire law and acting within an NHCM’s scope of practice as defined in New Hampshire law. Coverage includes, but is not limited to home deliveries. Out-of-Network NHCM services are not covered.

Benefits are available for urgent and emergency care as described in Section 6 and all of the Medically Necessary Covered Services described in this Section with respect to pregnancy, tests and surgery related to pregnancy, complications of pregnancy, termination of pregnancy or miscarriage. Ultrasounds in pregnancy are covered only when Medically Necessary. Please see subsection VI “Important Information About Other Covered Services,” C, “Infertility Diagnostic Services” for important restrictions regarding infertility treatment.

In the Service Area, no Benefits are available for Out-of-Network maternity care unless the services are authorized in advance by the Member’s PCP and Precertified in advance by Anthem. No Benefits are available for maternity care or related care outside the Service Area when:

- The delivery occurs outside the Service Area within 30 days of the baby’s due date, as established by the Network Provider who furnishes the mother’s prenatal care, and
- The care is not approved by the mother’s PCP Referral before the mother leaves the Service Area. Anthem must also approve Out-of-Network care before the mother leaves the Service Area.

Please see Section 3 “Access to Care Through Your Primary Care Provider (PCP),” IV, “Plan Approval for Specialized Care,” for important limitations on access to Out-of-Network Services.

C. Outpatient Facility Care: in the Outpatient Department of a Hospital, a Short Term General Hospital’s Ambulatory Surgical Center, Hemodialysis Center or Birthing Center. In addition to Preventive Care commonly provided in an Outpatient facility (see A, above), Benefits are available for Medically Necessary
facility and professional services in the Outpatient department of a Short Term General Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center. Coverage includes the following:

1. Medical exams and consultations by a physician,
2. Operating room for surgery or delivery of a baby,
3. Physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy,
4. Hemodialysis, chemotherapy, radiation therapy, infusion therapy,
5. CT Scan, MRI,
6. Medical supplies, drugs, other ancillaries, facility charges, including but not limited to facility charges for observation. Observation is a period of up to 24 hours during which your condition is monitored to determine if Inpatient care is Medically Necessary.
7. Laboratory and x-ray tests (including ultrasounds).

Please note that Ambulatory Surgical Centers and Birthing Centers must have a written payment agreement with Anthem or with their local Blue Cross and Blue Shield plan. Otherwise, the center is not a Designated Provider and no Benefits will be available for services provided to you in the facility. This exclusion applies even if the care is prescribed by a Designated Provider and meets Anthem’s definition of Medical Necessity.

Also, see subsection III, “Outpatient Physical Rehabilitation Services”.

D. Emergency Room Visits for Emergency Care. Covered Services are shown on your Cost Sharing Schedule. Please see Section 6 for important guidelines about “Urgent and Emergency Care.”

E. Ambulance Services. Benefits are available for Medically Necessary ambulance transport to a medical facility for Emergency Care. For example, coverage includes ambulance transport to a hospital from the scene of an accident or to a hospital from your home due to symptoms of a heart attack.

In addition to the limitations and Exclusions listed in Section 8 “Limitations and Exclusions,” the following limitations apply to Ambulance Services:

- Nonemergency ambulance transport is not covered. If transport in a non-emergency vehicle (such as by car) is medically appropriate, ambulance transport is not covered. No Benefits are available for the cost of transport in vehicles such as chair ambulance, car or taxi.
- No Benefits are provided for ambulance transportation to or from medical appointments. No Benefits are provided for non-ambulance transportation to or from medical appointments.
- Benefits are provided for air ambulance transport furnished by an air ambulance service to take you to a hospital only when it is Medically Necessary for you to be transported by air rather than ground ambulance. If Anthem determines that air ambulance transportation was not Medically Necessary, and that ground ambulance would have been Medically Necessary, Anthem will provide the Maximum Allowable Benefit for a ground ambulance. In this case, you pay the difference between the Maximum Allowable Benefit and the air ambulance charge.

F. Telemedicine Services. Telemedicine is the delivery of Covered Services by a Network Provider to a Member by means of audio, video or other electronic media for the purposes of diagnosis, consultation or treatment
without in-person (face to face) contact between the provider and Member. Telemedicine does not include the use of audio-only telephone or facsimile.

Benefits are available for telemedicine service provided that all of the following conditions are met:

- The services must be furnished by your PCP or approved in advance by your PCP’s Referral,
- The services would be covered if they were delivered during an in-person consultation instead of by telemedicine, and
- The services must be Medically Necessary as defined in Section 14 and
- Both the Network Provider and the Member must be present and participating during a telemedicine service.

Except as stated above, no Benefits are available for telemedicine services.

Cost sharing amounts for Covered telemedicine Services are the same as for similar services as shown on your Cost Sharing Schedule.

The Maximum Allowable Benefit for telemedicine services includes the provider's professional services and costs associated with operating the provider’s practice. Unless additional Benefits would be available if services were delivered during an in-person consultation instead of by telemedicine, no additional Benefits are available for costs such as a provider’s or Member’s telephone and/or facsimile or e-mail transmissions, technology hardware or software costs, office, facility or home operating costs or other site location costs, fees for use of a facility or costs for equipment or for the services of vendors, including electronic/internet service provider costs.

### III. Outpatient Physical Rehabilitation Services

Benefits are available for Medically Necessary Outpatient Physical Rehabilitation Services. Coverage includes the following:

A. Physical Therapy, Occupational Therapy and Speech Therapy in an office or in the Outpatient department of a Short Term General Hospital or Skilled Nursing Facility. Benefits may be limited, as shown on your Cost Sharing Schedule.

Physical therapy must be furnished by a licensed physical therapist. Occupational therapy must be furnished by a licensed occupational therapist. Speech therapy must be furnished by a licensed speech therapist. Otherwise, no Benefits are available.

Speech therapy services must be Medically Necessary to treat speech and language deficits or swallowing dysfunctions during the acute care stage of an illness or injury. Otherwise, no Benefits are available. Coverage for speech therapy is limited to the following speech therapy services:

1. An evaluation by a licensed speech therapist to determine if speech therapy is Medically Necessary, and
2. Individual speech therapy sessions (including services related to swallowing dysfunctions) by a licensed speech therapist.

Physical, occupational and speech therapy services must be furnished during the acute care stage of an illness or injury. Therapy is covered for long-term conditions only when an acute medical condition occurs during the illness, such as following surgery.

No Benefits are available for therapy furnished beyond the acute care stage of an illness or injury. Therapy services must be restorative, with the expectation of concise, measurable gains and goals as judged by your physician and by Anthem. Services must provide significant improvement within a reasonable and generally predictable period of
time. Services must require the direct intervention, skilled knowledge and attendance of a licensed physical, occupational or speech therapist. No Benefits are available for on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes, including lifestyle changes affecting the voice. Such on-going services are not covered, even if ordered by your physician or supervised by skilled program personnel. In addition to the “Limitations and Exclusions” listed in Section 8, no Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No Benefits are available for educational reasons or for Developmental Disabilities, except as stated in D, “Early Intervention Services,” below. No Benefits are available for sport, recreational or occupational reasons.

Physical therapy for TMJ disorders is not covered.

B. Cardiac Rehabilitation. Benefits are available for Outpatient cardiac rehabilitation programs. The program must meet Anthem’s standards for cardiac rehabilitation. Otherwise, no Benefits are available. Please call Anthem at 1-800-531-4450 to determine program eligibility.

Covered Services are: exercise and education under the direct supervision of skilled program personnel in the intensive rehabilitation phase of the program. The program must start within three months after a cardiac condition is diagnosed or a cardiac procedure is completed. The program must be completed within six months of the cardiac diagnosis or procedure.

No Benefits are available for portions of a cardiac rehabilitation program extending beyond the intensive rehabilitation phase. On-going or life-long exercise and education maintenance programs intended to maintain fitness or to reinforce permanent lifestyle changes are not covered, even if ordered by your physician or supervised by skilled program personnel.

C. Chiropractic Care. You do not need a Referral from your PCP to be eligible for Benefits. However, Covered Services must be furnished by a Network Chiropractor. Otherwise, no Benefits are available. Benefits may be limited as shown on your Cost Sharing Schedule.

The following are Covered Services when furnished by a Network Chiropractor:

1. Office visits for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment, and

2. Medically Necessary diagnostic laboratory and x-ray tests.

In addition to the “Limitations and Exclusions” stated in Section 8, the following limitations apply specifically to chiropractic care:

- Wellness care is not covered.
- The services must be Medically Necessary for the treatment of an illness or injury that is diagnosed or suspected by a Network Chiropractor or another physician, and
- Chiropractic care must be provided in accordance with New Hampshire law.

You may choose to receive noncovered services. However, you are responsible for the full cost of any chiropractic care that is not covered, as stated in this subsection.

D. Early Intervention Services. Early intervention services are covered for eligible Members from birth to the Member’s third birthday. Eligible Members are those with significant functional physical or mental deficits due to a Developmental Disability or delay. Covered Services include Medically Necessary physical, speech/language and occupational therapy, nursing care, and psychological counseling provided by Network Behavioral Health Providers,
such as Clinical Social Workers. Physical, speech and occupational therapy visits do not count toward any annual limits that may apply to A, (above). However, Benefits may be limited, as shown on your Cost Sharing Schedule.

IV. Home Care

Benefits are available for Medically Necessary Home Care. Covered Services are limited to the following:

A. **Physician Services** - physician visits to your home or place of residence to furnish medical/surgical care that is the same as or similar to services ordinarily provided in an office setting.

B. **Home Health Agency Services**. Benefits are available for Medically Necessary services furnished by a Network Home Health Agency in your home or other place of residence. In limited circumstances, Out-of-Network Services may be approved in advance by your PCP and by Anthem, provided that the Out-of-Network Provider is a BlueCard Provider. Benefits may be limited as shown on your Cost Sharing Schedule.

Benefits are available only when, due to the severity of a medical condition, it is not reasonably possible for you to travel from your home to another treatment site.

Covered Services are limited to the following:

1. Part-time or intermittent skilled nursing care by, or under the supervision of a Registered Nurse,

2. Part-time or intermittent home health aide services that consist primarily of caring for you under the supervision of a Registered Nurse,

3. Prenatal and postpartum homemaker visits. Homemaker visits must be Medically Necessary. Otherwise, no Benefits are available. For example, if you are confined to bed rest or your activities of daily living are otherwise restricted by order of your Network Physician, prenatal and/or postpartum homemaker visits may be considered Medically Necessary. When determining the Medical Necessity of such services, your physician will consult with Anthem’s case manager.

4. Physical, occupational, and speech therapy. Therapy provided by a Home Health Agency does not count toward annual limits that may apply to III, A (above).

5. Nonprescription medical supplies and drugs. Nonprescription medical supplies and drugs may include surgical dressings and saline solutions. Prescription drugs, certain intravenous solutions and insulin are not included. If your Group has purchased a Pharmacy Rider, see your Rider for coverage information.

C. **Hospice**. Hospice care is home management of a terminal illness. Benefits are available for Covered Services, provided that the following conditions are met:

- Care must be approved in advance by the patient’s PCP and Precertified by Anthem,

- Care must be furnished by a Network Hospice Provider. In limited circumstances, Out-of-Network Services may be approved in advance by your PCP and by Anthem, provided that the Out-of-Network Provider is a BlueCard Provider.

- The patient must have a terminal illness with a life expectancy of six months or less, as certified by a physician,

- The patient or his/her legal guardian must make an informed decision to focus treatment on comfort measures when treatment to cure the condition is no longer possible or desired,
• The patient or his/her legal guardian, the patient’s physician and medical team must support hospice care because it is in the patient’s best interest, and

• A primary care giver must be available on an around-the-clock basis. A primary care giver is a family member, friend or hired help who accepts 24-hour responsibility for the patient’s care. The primary care giver does not need to live in the patient’s home.

The hospice provider and Anthem will establish an individual hospice plan that meets your individual needs. Each portion of a hospice plan must be Medically Necessary and specifically approved in advance by Anthem’s Precertification. Otherwise, no Benefits are available. Covered Services that may be part of the individual hospice plan are:

1. Skilled nursing visits,
2. Home health aide and homemaker services,
3. Physical therapy for comfort measures. These therapy services do not count toward annual visit limits that may apply to III, A, “Physical Therapy, Occupational Therapy and Speech Therapy” (above),
4. Social service visits,
5. Durable medical equipment and medical supplies. These items do not count toward any annual dollar maximum stated on page 1 of your Cost Sharing Schedule for “Medical Equipment, Medical Supplies and Prosthetics.”
6. Respite care (in the home) to temporarily relieve the primary care giver from care-giving functions,
7. Continuous care, which is additional respite care to support the family during the patient’s final days of life,
8. Bereavement services provided to the family or primary care giver following the death of the hospice patient.

D. Infusion Therapy. Benefits are available for Medically Necessary home infusion therapy furnished by a licensed infusion therapy provider. Covered Services are:

1. Home nursing services for intravenous antibiotic therapy, chemotherapy or parenteral nutrition therapy,
2. Antibiotics, chemotherapy agents, medications and solutions used for parenteral nutrients,
3. Associated supplies and portable, stationary or implantable infusion pumps.

E. Durable Medical Equipment, Medical Supplies and Prosthetics. Benefits are available for durable medical equipment (DME), medical supplies and prosthetic devices. Covered Services must be ordered in advance by your PCP and furnished by a Network Provider. Out-of-Network Benefits are not available.

Services covered under this subsection are subject to Deductible and/or Coinsurance for Durable Medical Equipment, Medical Supplies and Prosthetics as shown on page 1 of your Cost Sharing Schedule. These are separate cost sharing amounts that do not count toward meeting any other Deductible or Coinsurance requirement under this Certificate. Exceptions are stated below in this subsection.

1. Durable medical equipment (DME). Benefits are available for covered DME. In order to be Covered, the DME must meet all of the following criteria. Otherwise, no Benefits are available. The DME must be:

   • Primarily and customarily used for a medical purpose, and
• Useful only for the specific illness or injury that your physician has diagnosed or suspects, and
• Non-disposable and specifically designed and intended to withstand repeated use, and
• Appropriate for use in the home.

Examples of covered DME include, but are not limited to: crutches, apnea monitors, oxygen and oxygen equipment, wheelchairs, special hospital type beds or home dialysis equipment. Enteral pumps and related equipment are covered for Members who are not capable of ingesting enteral formula orally. Oxygen humidifiers are covered if prescribed for use in conjunction with other covered oxygen equipment.

Benefits are available for Medically Necessary external insulin infusion pumps for insulin dependent diabetics. External insulin pumps must be approved in advance by Anthem. To determine eligibility, please ask your physician to contact Anthem for prior approval before you purchase the pump. Anthem will require treatment and clinical information in writing from your physician. Anthem will review the information and determine in writing whether the services are covered or excluded under the terms of this Certificate. Anthem’s review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including Copayment, Deductible, and Coinsurance, requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate. Please see subsection II “Outpatient Services,” A “Preventive Care” (above in this Section) for information about external insulin pump education. Implantable insulin infusion pumps are not covered. Anthem’s definition of Medical Necessity is stated in Section 14.

Benefits are available for orthopedic braces for support of a weak portion of the body or to restrict movement in a diseased or injured part of the body.

Benefits are available for one hearing aid per ear each time a hearing aid prescription changes for Members who are 18 years old or younger. No Benefits are available for hearing aids for Members who are 19 years old or older.

2. Medical Supplies. Benefits are available for medical supplies. In order to be covered, medical supplies must be small, disposable items designed and intended specifically for medical purposes and appropriate for treatment of the specific illness or injury that your physician has diagnosed. Otherwise, no Benefits are available.

Examples of covered medical supplies include: needles and syringes, ostomy bags and skin bond necessary for colostomy care. Eyewear (frames and/or lenses or contact lenses) is covered only if the lens of your eye has been surgically removed or is congenitally absent. Please note: If your Group has purchased an eyewear rider, please see your rider for information about eyewear for routine vision correction.

Other covered medical supplies are:

• Diabetic supplies. Diabetic supplies are covered for Members who have diabetes. Examples of covered diabetic supplies include, but are not limited to: diabetic needles and syringes, blood glucose monitors, test strips and lancets. Coverage is provided under this subsection when diabetic supplies are purchased from a licensed durable medical equipment provider.

Please note: if your Group has purchased a Pharmacy Rider, coverage and cost sharing is provided as described in the rider for diabetic supplies purchased at a pharmacy. If your Group has not purchased a Pharmacy Rider, and you purchase diabetic supplies at a pharmacy, coverage will be provided under the terms of this subsection and will be subject to the cost sharing amounts shown on page 1 of your Cost Sharing Schedule for Medical Equipment, Medical Supplies and Prosthetics.

• Enteral formula and modified low protein food products. Benefits are available for enteral formulas required for the treatment of impaired absorption of nutrients caused by disorders
affecting the absorptive surface, functional length or motility of the gastrointestinal tract. Benefits are available for food products modified to be low protein for persons with inherited diseases of amino acids and organic acids. Your physician must issue a written order stating that the enteral formula and/or food product is:

- Needed to sustain life, and is
- Medically Necessary; and is
- The least restrictive and most cost-effective means for meeting your medical needs.

Otherwise, no Benefits are available. Except as provided in this subsection or as required by law, no Benefits are available for nutrition and/or dietary supplements. No Benefits are available for 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.

Any Deductible, Coinsurance and Maximum Benefit stated on page 1 of your Cost Sharing Schedule specifically for Durable Medical Equipment, Supplies and Prosthetics do not apply to enteral formula and modified low protein food products. If you purchase enteral formula or food products modified to be low protein in an Outpatient setting, Benefits are subject to the cost sharing amounts shown under part II of your Cost Sharing Schedule “Outpatient Services” for “medical supplies”. For modified low protein food products, Benefits are limited to a total of $1,800 per Member, per Calendar Year.

3. **Prosthetic Devices.** Benefits are available for prosthetic devices that replace an absent body part or the function of a permanently impaired body part. Prosthetic limbs are covered. Prosthetic limbs are artificial devices that replace, in part or in whole, an arm or leg. Post-mastectomy breast prostheses and scalp hair prosthesis are other examples of covered prosthetic devices.

Coverage for external breast prostheses is limited to 2 prostheses per breast, per Calendar Year. The Maximum Allowable Benefit for breast prosthesis includes the cost of fitting for the prosthesis.

Clothing necessary to wear a covered prosthetic device is also covered. This includes stump socks worn with prosthetic limbs and post-mastectomy bras worn with breast prosthesis. Coverage for post-mastectomy bras is limited to 3 bras per Member, per Calendar Year.

A scalp hair prosthesis is an artificial substitute for scalp hair that is made specifically for you. Benefits are available for scalp hair prostheses for Members who have hair loss as a result of alopecia areata, alopecia totalis, or alopecia medicamentosa resulting from treatment of any form of cancer or leukemia and/or who have permanent hair loss as a result of injury. For Members who have hair loss as a result of alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia, Benefits are limited to a total of $350 per Member per Calendar Year.

You pay no Copayment, Deductible or Coinsurance for covered scalp hair prostheses. Any Deductible, Coinsurance and/or Maximum Benefit stated on page 1 of your Cost Sharing Schedule for Medical Equipment, Medical Supplies and Prosthetics do not apply to scalp hair prostheses.

To be eligible for Benefits for scalp hair prostheses, your physician must state in writing that the prosthesis is Medically Necessary. You must submit your physician’s statement with your claim.

Except as described above, no Benefits are available for scalp hair prostheses or wigs. For example, except as stated above, no Benefits are available for temporary hair loss. No Benefits are available for male pattern baldness.
4. **Limitations.** In addition to the “Limitations and Exclusions” listed in Section 8, the following limitations apply specifically to this subsection:

- Whether an item is purchased or rented, Benefits are limited to the Maximum Allowable Benefit. Benefits will not exceed the Maximum Allowable Benefit for the least expensive service that meets your medical needs. If your service is more costly than is Medically Necessary, you will be responsible for paying the difference between the Maximum Allowable Benefit for the least expensive service and the charge for the more expensive service.

If you rent or purchase equipment and Anthem pays Benefits equal to the Maximum Allowable Benefit for the equipment, no further Benefits will be provided for rental or purchase of the equipment.

- Anthem determines if equipment should be rented instead of purchased. For example, if your physician prescribes a hospital bed for short-term home use, Anthem will require that the bed must be rented instead of purchased if short-term rental is less expensive than the purchase price. In such instances, Benefits are limited to what Anthem would pay for rental, even if you purchase the equipment. You will be responsible for paying the difference between the Maximum Allowable Benefit for rental and the charge for purchase.

- Burn garments (or burn anti-pressure garments) are covered only when prescribed by your physician for treatment of third degree burns, deep second degree burns or for areas of the skin that have received a skin graft. Covered burn garments include gloves, face hoods, chin straps, jackets, pants, leotards, hose or entire body suits which provide pressure to burned areas to help with healing.

- Support stockings are covered for a diagnosis of phlebitis or other circulatory disease. Gradient pressure aids (stockings) are covered, provided that the stockings are prescribed by your PCP and are Medically Necessary, as defined in Section 14 “Definitions.” Anti-embolism stockings are not covered. Inelastic compression devices are not covered. The Maximum Allowable Benefit for covered gradient pressure aids includes the Benefit for fitting of the garments. No additional Benefits are available for fitting.

- Neither rental nor purchase of manual breast pumps is covered.

- Electric breast pumps are not covered. Exception: rental of an electric breast pump may be covered for up to two months, provided that the service meets Anthem’s definition of Medical Necessity, as stated in Section 14 “Definitions.” Purchase of an electric breast pump is not covered.

- Benefits are available for custom-fitted helmets or headbands (dynamic orthotic cranioplasty) to change the shape of an infant’s head only when the service is provided for moderate to severe asymmetry (nonsynostotic plagiocephaly and brachycephaly) and the condition meets the definition of a **reconstructive service** found in subsection VI, G, “Surgery” below in this Section. To be eligible for Benefits, the service must be Medically Necessary and the infant Member must be at least three months old, but no older than 18 months. Also, the infant must have completed at least two months of cranial repositioning therapy or physical therapy with no substantial improvement. Otherwise, no Benefits are available for cranial helmets or any other device intended to change the shape of a child’s head. Anthem’s definition of Medical Necessity is stated in Section 14.

- Benefits are available for broad or narrow band ultraviolet light (UVB) home therapy equipment only if the therapy is conducted under a physician’s supervision with regularly scheduled exams. The therapy is covered only for treatment of the following skin disorders: severe atopic dermatitis
and psoriasis, mild to moderate atopic dermatitis or psoriasis (when standard treatment has failed, as documented by medical records), lichen planus, mycosis fungoides, pityriasis lichenoides, pruritus of hepatic disease and pruritus of renal failure. UVB home therapy is not covered for any other skin disorder. Ultraviolet light A home therapy (UVA) is not covered. For information about ultraviolet light therapy, please see “Ultraviolet Light Therapy and Ultraviolet Laser Therapy for Skin Disorders,” in Section 8 “Limitations and Exclusions,” 1 “Limitations.”

5. **Exclusions.** In addition to the other limitations and exclusions stated in this Certificate, the following services are not covered. These exclusions apply, even if the services are provided, ordered or prescribed by a Designated Provider and even if the services meet Anthem’s definition of Medical Necessity found in Section 14 of this Certificate.

**No Benefits are available for:**

- Arch supports, corrective shoes, foot orthotics (and fittings, castings or any services related to footwear or orthopedic devices) or any shoe modification,
- Special furniture, such as seat lift chairs, elevators (including stairway elevators or lifts), back chairs, special tables and posture chairs, adjustable chairs, bed boards, bed tables, and bed support devices of any type including adjustable beds,
- Glasses, sports bras, nursing bras and maternity girdles or any other special clothing, except as stated in this subsection,
- Nonprescription supplies, first aid supplies, ace bandages, cervical pillows, alcohol, peroxide, betadine, iodine, or phisohex solution; alcohol wipes, betadine or iodine swabs, items for personal hygiene,
- Bath seats or benches (including transfer seats or benches), whirlpools or any other bath tub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans,
- Heat lamps, heating pads, hydrocoliator heating units, hot water bottles, batteries and cryo cuffs (water circulating delivery systems),
- Biomechanical limbs, computers, physical therapy equipment, physical or sports conditioning equipment, exercise equipment, or any other item used for leisure, sports, recreational or vocational purposes, any equipment or supplies intended for educational or vocational rehabilitation, vehicles, scooters or any similar mobility device,
- Safety equipment, including hats, belts, harnesses, glasses or restraints,
- Costs related to residential or vocational remodeling or indoor climate/air quality control, air conditioners, air purifiers, humidifiers, dehumidifiers, vaporizers and any other room heating or cooling device or system,
- Self-monitoring devices are not covered, except as stated in 2 “Diabetic Supplies” (above). No Benefits are available for TENS units for incontinence, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for Internet sites or software, or any other media instruction or for any other educational or instructional material, technology or equipment,

Dentures, orthodontics, dental prosthesis and appliances. No Benefits are available for appliances used to treat temporomandibular joint (TMJ) disorders.

Convenience Services are not covered under any portion of this Certificate. Please see Anthem’s definition of “Convenience Services” in Section 14. For the purposes of this subsection, Convenience Services include personal comfort items and any equipment, supply or device that is primarily for the convenience of
a Member, the Member’s family or a Designated Provider.

Except as specified in this subsection and in any amendment to this Certificate, no Benefits are available for the cost of medical equipment, supplies, prosthetics, materials or devices.

## V. Behavioral Health Care (Mental Health and Substance Abuse Care)

**A. Access to Behavioral Health Care.** Benefits are available for Medically Necessary Behavioral Health Care. Behavioral Health Care means the Covered Services described in this subsection for diagnosis and treatment of Mental Disorders and Substance Abuse Conditions.

- **Network Services.** You must receive Covered Services from a Network Behavioral Health Provider. Exceptions are stated directly below under “Out-Of-Network Services.”

  Please note: For Mental Disorders, a minimum of two office visits for diagnosis and three treatment visits will be covered each Contract Year without clinical review. The visits count toward any applicable visit maximum stated in part V of your Cost Sharing Schedule, “Behavioral Health Care.” Additional visits may be subject to clinical review.

  Your PCP may refer you to a Network Behavioral Health Provider, but PCP Referrals are not required for Behavioral Health Care.

- **Out-of-Network Services.** In limited instances, Anthem may determine that it is Medically Necessary for you to receive Covered Services from an Out-of-Network Provider. You (not your provider) must contact Anthem for Preauthorization before you receive any Out-of-Network Service, even if you are temporarily outside the Service Area for a definite period of time (such as students, vacationers and business travelers).

  Please call Anthem at 1-800-228-5975 to request Preauthorization.

  After you call, Anthem will send you a letter specifying the Preauthorized Out-of-Network Services. If your Behavioral Health Provider is named on the letter, you must receive Covered Services from the provider named. Otherwise, no Benefits will be available for the Out-of-Network Services.

  If Anthem notifies you that Out-of-Network Services are not approved, and you decide to receive the services, no Benefits will be available for the Out-of-Network Services and you will be responsible for the full cost of the care. No Benefits will be available for elective Inpatient or Outpatient care that can be safely delayed until you return to the Service Area or for care that a reasonable person would anticipate before leaving the Service Area. School infirmary facility or infirmary room charges are not covered under any portion of this Certificate. No Benefits are available for care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services.

  Please note: If Anthem Preauthorizes Out-of-Network Services for Mental Disorders, a minimum of two office visits with the Out-of-Network Provider for diagnosis and three treatment visits will be covered each Contract Year without clinical review. The visits count toward any applicable visit maximum stated in part V of your Cost Sharing Schedule, “Behavioral Health Care.” Additional visits may be subject to clinical review.

  If you fail to contact Anthem as required and Anthem later finds that your care did not meet the coverage criteria stated in this Certificate, no Benefits will be available and you will be responsible for the full cost of
the care. The term “Preauthorization” for Out-of-Network Services refers to Anthem’s written confirmation that it is Medically Necessary for you to receive the care outside the Network. Preauthorization is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including Copayment, Deductible, and Coinsurance, requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

- **Emergency Care.** Please see Section 6, “Urgent and Emergency Care.” You must notify Anthem of an emergency Inpatient admission within 48 hours after you are admitted or on the next business day after you are admitted, whichever is later.

B. **Covered Services.** Benefits are available for the diagnosis, crisis intervention and treatment of Mental Disorders and Substance Abuse Conditions.

- **A Mental Disorder** is a nervous or mental condition identified in the most current version of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association, excluding those disorders designated by a “V Code” and those disorders designated as criteria sets and axes provided for further study in the DSM. This term does not include chemical dependency such as alcoholism. A mental disorder is one that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical or biological cause(s) or disorder(s).

- **A Substance Abuse Condition** is a condition, including alcoholism or other chemical dependency, brought about when an individual uses alcohol and/or other drugs in such a manner that his or her health is impaired and/or ability to control actions is lost. Nicotine addiction is not a Substance Abuse Condition under the terms of this Certificate.

In determining whether or not a particular condition is a Mental Disorder or Substance Abuse Condition, Anthem will refer to the most current edition of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association and may also refer to the International Classification of Diseases (ICD) Manual.

**Benefits are available for the following Covered Services:**

1. **Outpatient/office visits.** Covered Services are: diagnosis and evaluation, therapy and counseling, medication checks and psychological testing, including but not limited to Medically Necessary psychological testing for bariatric surgery candidates. **Benefits for Outpatient/office visits may be limited, as shown on your Cost Sharing Schedule.** Visits for psychological testing and medication checks are covered, but do not count toward annual visit limits stated on your Cost Sharing Schedule. Emergency room visits are not covered under this subsection. Emergency room visits are covered under the terms of Section 6, “Urgent and Emergency Care.”

Outpatient/office visits for Substance Abuse Conditions may be furnished during the acute detoxification stage of treatment or during stages of rehabilitation.

Covered Services must be furnished by an Eligible Behavioral Health Provider acting within the scope of his or her license. Otherwise, no Benefits are available. As defined in D (below) and subject to all the terms of this subsection, Eligible Providers of Outpatient/office visits are: Licensed Clinical Social Workers, Licensed Clinical Mental Health Counselors, Community Mental Health Centers, Licensed Alcohol and Drug Abuse Counselors, Licensed Marriage and Family Therapists, Licensed Pastoral Psychotherapists, Psychiatrists, Psychiatric Advanced Practice Registered Nurses (APRN), and Licensed Psychologists.

2. **Telemedicine Services.** Telemedicine is the delivery of Covered Services by an Eligible Behavioral Health Provider in the Network to a Member by means of audio, video or other electronic media for the purposes of diagnosis, consultation or treatment without in-person (face to face) contact between the provider and Member. Telemedicine does not include the use of audio-only telephone or facsimile.
Benefits are available for telemedicine service provided that all of the following conditions are met:

- The services would be covered if they were delivered during an in-person consultation instead of by telemedicine, and
- The services must be Medically Necessary as defined in Section 14, and
- Both the Network Provider and the Member must be present and participating during a telemedicine services.

Except as stated above, no Benefits are available for telemedicine services.

Cost sharing amounts for Covered telemedicine Services are the same as for similar services as shown on your Cost Sharing Schedule.

*Telemedicine visits count toward any Outpatient/office visit limit described in 1 “Outpatient/office visits” above and on your Cost Sharing Schedule.*

The Maximum Allowable Benefit for telemedicine services includes the provider’s professional services and costs associated with operating the provider’s practice. Unless additional Benefits would be available if services were delivered during an in-person consultation instead of by telemedicine, no additional Benefits are available for costs such as, but not limited to a provider’s or Member’s telephone and/or facsimile or e-mail transmissions, technology hardware or software costs, office, facility or home operating costs or other site location costs, fees for use of a facility or costs for equipment or for the services of vendors, including electronic/internet service provider costs.

3. **Partial Hospitalization and Intensive Outpatient Treatment Programs.** Benefits are available for Partial Hospitalization and Intensive Outpatient Treatment Programs (sometimes called “day/evening” programs) for treatment of Mental Disorders and for Substance Abuse rehabilitation. Covered Services include facility fees, counseling and therapy services typically provided by a Partial Hospitalization or Intensive Outpatient Treatment Program. *Benefits may be limited, as shown on your Cost Sharing Schedule.*

Covered Services must be furnished by a Partial Hospitalization Program or Intensive Outpatient Treatment Program as defined in D, below and subject to all of the terms of this subsection. Otherwise, no Benefits are available.

4. **Inpatient care.**

- **For Mental Disorders,** Covered Services include Medically Necessary semi-private room and board, nursing care and other facility fees, Inpatient counseling and therapy services typically provided as part of an Inpatient admission for treatment of Mental Disorders. *Inpatient Benefits may be limited, as shown on your Cost Sharing Schedule.* Covered Services must be furnished by an Eligible Behavioral Health Provider, as defined in D (below) and subject to all of the terms of this subsection. Otherwise, no Benefits are available. Eligible Behavioral Health Providers of Inpatient facility care are: Private Psychiatric Hospitals, Public Mental Health Hospitals, Residential Psychiatric Treatment Facilities and Short Term General Hospitals.

- **For Substance Abuse Conditions,** Covered Services include Medically Necessary semi-private room and board, nursing care and other facility fees, Inpatient counseling and therapy services typically provided as part of an Inpatient admission for treatment of Substance Abuse Conditions during the acute detoxification stage of treatment or during stages of rehabilitation. *Inpatient Benefits may be limited, as shown on your Cost Sharing Schedule.* Covered Services must be furnished by an Eligible Behavioral Health Provider, as defined in D (below) and subject to all of the terms of this subsection. Otherwise, no Benefits are available. Eligible Behavioral Health Providers of substance abuse detoxification are: Short Term General Hospitals and Private
Psychiatric Hospitals. Eligible Providers of Inpatient facility rehabilitation are: Private Psychiatric Hospitals and Substance Abuse Treatment Providers.

Please note: Inpatient admissions ordered by a medical/surgical physician (not an Eligible Behavioral Health Provider) for medical detoxification are not subject to the terms of this subsection. Precertification and notification rules are stated in Sections 3 “Access to Care Through Your Primary Care Provider (PCP)” and 6 “Urgent and Emergency Care.” Benefits are available as stated in subsection I, “Inpatient Services,” and are subject to any limits for medical detoxification shown on page 4 of your Cost Sharing Schedule.

5. **Scheduled Ambulance Transport.** Benefits are available for Medically Necessary scheduled ambulance transport from one facility to another. If transport in a non-emergency vehicle (such as by car) is medically appropriate, ambulance transport is not covered. No Benefits are available for the cost of transport in vehicles such as chair ambulance, car or taxi. Please note: Emergency ambulance transportation is not covered under this subsection. Please see subsection II, “Ambulance Services” for complete information.

C. **Additional Benefits.** For Mental Disorders, annual limits may show on your Cost Sharing Schedule. If you exhaust the annual limits, additional Benefits are available for Covered Services you receive in treatment of the following Mental Disorders:

- Schizophrenia and other psychotic disorders such as, but not limited to, paranoia
- Schizoaffective disorder
- major depressive disorder
- Bipolar disorder
- Obsessive-compulsive disorder
- Panic disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa and
- Chronic post-traumatic stress disorder

Annual maximums do not apply to the above-listed illnesses. Inpatient Services must be preauthorized by Anthem and furnished by a Network Behavioral Health Provider, as explained in A “Access to Behavioral Health Care,” (above in this subsection).

D. **Eligible Behavioral Health Providers.** As approved by Anthem, Eligible Behavioral Health Providers include the following:

**Licensed Clinical Social Worker** - an individual who is licensed as a clinical social worker under New Hampshire law. A Clinical Social Worker whose practice is conducted outside New Hampshire must be licensed or certified to practice independently as a Clinical Social Worker according to the law in the state where the individual’s practice is conducted. Otherwise, the individual is not an Eligible Provider.

**Licensed Clinical Mental Health Counselor** - an individual who is licensed as a clinical mental health counselor under New Hampshire law. A Clinical Mental Health Counselor can also be an individual who is licensed or certified to practice independently as a Clinical Mental Health Counselor according to the provisions of law in another state where his or her practice is conducted.

**Community Mental Health Center** - a licensed center approved by the Director of the Division of Mental Health and Developmental Services, Department of Health and Human Services of the State of New Hampshire as a Community Mental Health Center as defined in the Community Mental Health Centers Act of 1963 or licensed in accordance with the provisions of the laws of the state in which they practice which meet or exceed the certification standards of the State of New Hampshire.
**Intensive Outpatient Treatment Program** - an intensive, nonresidential behavioral health program designed to reduce or eliminate the need for an Inpatient admission. The program must provide multidisciplinary structured, therapeutic group treatment under the direction of a qualified Eligible Behavioral Health Provider. A qualified provider is an Eligible Behavioral Health Provider, as defined in this subsection, who has achieved at least a masters degree in his or her field of practice and is practicing within the scope of his or her license. In most instances, the program will operate at least three hours per day, three days per week.

**Licensed Alcohol and Drug Abuse Counselor** - an individual who is licensed as an Alcohol and Drug Abuse Counselor under New Hampshire law. An Alcohol and Drug Abuse Counselor whose practice is conducted outside New Hampshire must be licensed or certified to practice independently as an Alcohol and Drug Abuse Counselor according to the law in the state where the individual’s practice is conducted. Otherwise, the individual is not a Designated Provider.

**Licensed Marriage and Family Therapist** - an individual who is licensed as a marriage and family therapist under New Hampshire law. A Marriage and Family Therapist can also be an individual who is licensed or certified to practice independently as a Marriage and Family Therapist according to the provisions of law in another state where his or her practice is conducted. To be eligible for Benefits, Marriage and Family Therapists must furnish Covered Services as stated in this subsection. Marriage or couple’s counseling is not covered under this Certificate.

**Partial Hospitalization Program** - means an intensive nonresidential behavioral health program designed to reduce or eliminate the need for an Inpatient admission. The program must provide multidisciplinary structured, therapeutic group treatment under the direction of a qualified Eligible Behavioral Health Provider. A qualified provider is an Eligible Behavioral Health Provider, as defined in this subsection, who has achieved at least a masters degree in his or her field of practice and is practicing within the scope of his or her license. In most instances, the program will operate at least 6 hours per day, five days per week.

**Licensed Pastoral Psychotherapist** - a professional who is licensed under New Hampshire law and who is a fellow or diplomate in the American Association of Pastoral Counselors.

**Private or Public Hospital** - a licensed Private Psychiatric Hospital or Public Mental Health Hospital that provides diagnostic services, treatment and care of acute Mental Disorders under the care of a staff of physicians. A Private or Public Hospital must provide 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.) and must keep permanent medical history records.

**Psychiatrist** - a professional who is a licensed physician and is Board Certified or Board Eligible according to the regulations of the American Board of Psychiatry and Neurology.

**Psychiatric Advanced Practice Registered Nurse** - a professional who is licensed as a registered nurse in advanced practice by the State of New Hampshire or licensed in accordance with the provisions of the laws of the state in which they practice and who is certified as a clinical specialist in psychiatric and mental health nursing.

**Licensed Psychologist** - a professional who is licensed under New Hampshire law, or under a similar statute in another state, which meets or exceeds the standards under New Hampshire law or is certified or licensed in another state and listed in the National Register of Health Service Providers in Psychology.

**Residential Psychiatric Treatment Facility** - a licensed facility approved by the Director of the Division of Mental Health and Developmental Services, Department of Health and Human Services of the State of New Hampshire.

**Short Term General Hospital** - a health care institution having an organized professional and medical staff and Inpatient facilities which care primarily for patients with acute diseases and injuries with an average patient length of stay of 30 days or less.

**Substance Abuse Treatment Provider** - a facility that is approved by Anthem and which meets the following criteria: is licensed, certified or approved by the state where located to provide substance abuse rehabilitation, and is affiliated with a hospital under a contractual agreement with an established patient referral system, or is accredited by the Joint Commission on Accreditation of a Hospital as a Substance Abuse Treatment Provider.
Note: Benefits are provided for Covered Services furnished by Eligible Behavioral Health Providers located outside New Hampshire only when the services are Preauthorized by Anthem in advance or as otherwise required under this Certificate, and the provider is licensed according to state requirements that are substantially similar to those required by Anthem. Also, the provider must meet the educational and clinical standards that Anthem requires for health care provider eligibility. Otherwise, no Benefits are available.

E. **Criteria for Coverage.** To be eligible for Benefits, Covered Services must be Medically Necessary and must meet the following criteria:

Benefits are available only for Mental Disorders and Substance Abuse Conditions that are subject to favorable modification through therapy. The Mental Disorder or Substance Abuse Condition must be shown to affect the ability of a Member to perform daily activities at work, at home, or at school. Benefits are available for approved expenses arising from the diagnosis, evaluation and treatment of Mental Disorders and Substance Abuse Conditions. Additionally, Benefits are available for approved periodic care for a chronic Mental Disorder or Substance Abuse Condition to prevent deterioration of function.

Services must be problem-focused and goal-oriented and demonstrate ongoing improvement in a Member’s condition or level of functioning.

Services must be in keeping with national standards of mental health or substance abuse professional practice as reflected by scientific and peer specialty literature.

F. **Exclusions.** In addition to the “Limitations and Exclusions” stated in Section 8, no Benefits are available for the following:

Except as required by law, services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through therapy.

- Duplication of services (the same services provided by more than one therapist during the same period of time),
- Except for the psychological testing covered in B, 1, “Outpatient/office visits”, no Benefits are available for testing, therapy, counseling or any non-surgical Inpatient or Outpatient service, care or program to treat obesity or for weight control. Benefits are available for Covered Services to treat Mental Disorders and Substance Abuse Conditions caused by or resulting from obesity or morbid obesity. No Benefits are available for weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- Custodial Care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling,
- Services for nicotine withdrawal or nicotine dependence,
- Psychoanalysis,
- Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings,
- Missed appointments,
- Except as stated in B “Covered Services,” 2 “Telemedicine Services,” above, telephone therapy or any other therapy or consultation that is not “face-to-face” interaction between the patient and the provider,
- Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition,

- Care extending beyond therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting.

- No Benefits are available for methadone or suboxone maintenance therapy or programs or any similar maintenance therapy or program or for any related testing, supplies, visits or treatment.

- Experimental/Investigational Services or nontraditional therapies such as crystal or aroma therapies,

- With the exception of Emergency Care, no Benefits are available for services that you receive on the same day that you participate in a partial hospitalization or intensive treatment program.

VI. IMPORTANT INFORMATION ABOUT OTHER COVERED SERVICES

This subsection includes services that are covered and often involve Covered Services defined elsewhere in this Section. For example, the “Organ and Tissue Transplants” described in D (below) involve Inpatient and Outpatient services described throughout subsection I, “Inpatient Services” and II, “Outpatient Services” (above in this Section).

The limitations and exclusions stated in this subsection are in addition to those stated in Section 8, “Limitations and Exclusions.” Limitations and exclusions apply even if you receive services from your physician or according to your physician’s order or according to the recommendation of another Designated Provider and even if the service meets Anthem’s definition of Medical Necessity, which is stated in Section 14. No Benefits are available for any services performed in conjunction with, arising from, or as a result of complications of a non-covered service. All of the plan rules, terms and conditions stated elsewhere in this Certificate apply to the services in this subsection.

A. Dental Services

Dental Services. Dental Services are defined as any care relating to the teeth and supporting structures, such as the gums, tooth sockets in the jaw and the soft or bony portions of upper and lower jaws that contain the teeth. For the purposes of this subsection, Dental Services also include care of the temporomandibular joint (TMJ) to the extent stated below and Emergency Care in a hospital emergency room.

Under this Certificate, Benefits are limited to the following Covered Dental Services. No other Dental Service is a Covered Service. Except as specifically stated in this subsection, Covered Services must be approved in advance by your PCP and furnished by a Network Provider. Otherwise, no Benefits are available. The following Dental Services are Covered Services:

1. Initial emergency treatment within 24 hours of an accidental injury to sound natural teeth. Cost sharing amounts for emergency treatment are shown under parts I and II of your Cost Sharing Schedule, “Inpatient Services” and “Outpatient Services.” No Benefits are available for emergency treatment if you damage your teeth or appliances as a result of biting or chewing. No Benefits are available for emergency treatment to repair, restore or replace items such as fillings, crowns, caps or appliances that are damaged as a result of an accident. No Benefits are available for Dental Services furnished after the initial 24-hour period, except as stated below in this subsection. The 24-hour limitation applies, even if the service cannot be rendered during the 24-hour period. The 24-hour limitation applies, even if your condition meets the definition of Emergency Care stated in Section 6 “Urgent and Emergency Care,” and/or the service is prescribed by a Designated Provider and/or meets Anthem’s definition of Medical Necessity which is stated in Section 14.

You do not need to obtain your PCP’s Referral for the initial Emergency Care in the emergency room of a hospital. All other treatment within 24 hours of accidental injury must be approved in
advance by your PCP and furnished by a Network Provider. Otherwise, no Benefits are available.

Cost sharing amounts for Covered Inpatient and Outpatient Services are shown under parts I and II of your Cost Sharing Schedule.

2. **Oral Surgery** limited to the following:

a. Surgical removal (extraction) of erupted teeth before radiation therapy for malignant disease. Services must be approved in advance by your PCP and furnished by a Network Provider. Otherwise, no Benefits are available. Benefits are limited to:

   - The surgeon’s fee for the surgical procedure,
   - Intravenous sedation furnished by the operating dentist or oral surgeon,
   - General anesthesia furnished by a licensed anesthesiologist or anesthetist who is not the operating dentist or oral surgeon.

   No Benefits are available for related preoperative or postoperative care, including medical, laboratory and x-ray services. No Benefits are available for related facility fees unless the provisions of 4 (below) apply.

b. Surgical correction of a facial bone fracture (not to include the portion of upper and lower jaws that contain the teeth, except as otherwise stated in this subsection) and surgical removal of a lesion or tumor by a dentist or oral surgeon are covered to the same extent as any other surgical procedure covered under this Certificate. Services must be approved in advance by your PCP and furnished by a Network Provider. Otherwise, no Benefits are available.

Cost sharing amounts for covered oral surgery, anesthesia, office and facility care are shown under parts I and II of your Cost Sharing Schedule, “Inpatient Services” and “Outpatient Services.”

3. **Surgical correction or repair of the temporomandibular joint (TMJ).** Surgical correction or repair of the TMJ is covered, provided that the Member has completed at least five months of medically documented unsuccessful non-surgical treatment. The non-surgical treatment is not covered. Coverage is limited to surgical evaluation and surgical procedures that are Medically Necessary to correct or repair a disorder of the TMJ caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations. Otherwise, no Benefits are available. Administration of general anesthesia by a licensed anesthesiologist or anesthetist is covered in conjunction with a covered surgery. Medically Necessary Inpatient and Outpatient hospital care is covered in conjunction with a covered surgery, subject to all of the terms of this Certificate. Cost sharing amounts for surgery, anesthesia and facility care are shown under parts I and II of your Cost Sharing Schedule, “Inpatient Services” and “Outpatient Services.”

   Services must be approved in advance by your PCP and furnished by a Network Provider. Otherwise, no Benefits are available. Cost sharing amounts for surgery, anesthesia and facility care are shown under parts I and II of your Cost Sharing Schedule.

   Except as stated in this subsection, no Benefits are available for diagnosis, evaluation or treatment of the TMJ. Diagnostic arthroscopy for TMJ disorders and trigger point injections are not covered. No Benefits are available for non-surgical TMJ services. No Benefits are available for x-rays of the teeth or orthopantagrams. Physical therapy for TMJ disorders is not covered. TMJ appliances or appliance adjustments are not covered. No Benefits are available under any portion of this Certificate for orthodontia, orthodontics, orthodontic care, dentures or dental prosthesis for TMJ disorders.
4. **Benefits are available for hospital facility charges (Inpatient or Outpatient), surgical day care facility charges and general anesthesia** furnished by a licensed anesthesiologist or anesthetist when it is Medically Necessary for certain Members to undergo a dental procedure under general anesthesia in a hospital facility or surgical day care facility. Members who are eligible for facility and general anesthesia Benefits are:

a. Children under the age of 6. The child’s dental condition must be so complex that the dental procedure must be done under general anesthesia and must be done in a hospital or surgical day care facility setting. A licensed dentist and the child’s PCP must determine in advance that anesthesia and hospitalization are Medically Necessary due to the complexity of the child’s dental condition. Anthem must approve the care in advance.

b. Members who have exceptional medical circumstances or a Developmental Disability. The exceptional medical circumstance or the Developmental Disability must be one that places the Member at serious risk unless the dental procedure is done under general anesthesia and must be done in a hospital or surgical day care facility setting. The Member’s PCP and Anthem must approve the services in advance.

Cost sharing amounts for Inpatient and Outpatient facility charges and for general anesthesia are shown under parts I and II of your Cost Sharing Schedule. No Benefits are available for a noncovered dental procedure, even when your physician and Anthem authorize hospitalization and anesthesia for the procedure.

5. **Limitations and Exclusions.** In addition to the “Limitations and Exclusions” stated in Section 8, the following limitations and exclusions apply to Dental Services:

a. Except as specifically stated in 1 to 4 above, no Benefits are available for facility fees, professional fees, anesthesia related to Dental Services or any other care relating to the teeth and supporting structures, such as the gums, tooth sockets in the jaw and the soft or bony portions of upper and lower jaws that contain the teeth. Except as specifically stated in 3 above, no Benefits are available for any service relating to care of the temporomandibular joint (TMJ). Except as stated in 4 (above) for facility and general anesthesia services, no Benefits are available for treatment of cavities or care of the gums. No Benefits are available for any condition that is related to, arising from or is a complication of a noncovered service.

b. The Maximum Allowable Benefit for surgery includes the Benefit payment for IV sedation and/or local anesthesia. For any surgical Dental Service covered under this subsection, no Benefits beyond the surgical Maximum Allowable Benefit are available for IV sedation and/or local anesthesia.

c. Except as stated in 4 above, no Benefits are available for treatment or evaluation of a periodontal disorder, disease or abscess. Osseous and flap procedures, scaling, root planning, prophylaxis and periodontal evaluations are not covered.

d. No Benefits are available for preventive Dental Services.

e. Except as stated in 1 and 4 above in this subsection, no Benefits are available for restorative Dental Services, even if the underlying dental condition affects other health factors. No Benefits are available for noncovered dental procedures, even when your physician and Anthem authorize hospitalization and general anesthesia covered under this subsection.

f. X-rays of the teeth are covered only when the terms of 1 (above) are met. Otherwise, x-rays of the teeth are not covered under any portion of this Certificate. Orthopantagrams are not covered.

g. Orthodontia, braces, false teeth and biofeedback training are not covered under any portion of this Certificate. Orthopedic repositioning splints and occlusal adjustments are not covered under any
portion of this Certificate. Night guards, trismus appliances, bruxism splints or occlusal guards are not covered under any portion of this Certificate.

h. No benefits are available for local anesthesia services. Except as specifically stated in this subsection, no Benefits are available for office services, anesthesia services or facility fees. Except as stated in 4 above in this subsection, no Benefits are available for surgical exposure of impacted teeth to aid eruption, osseous and flap procedures, scaling, root planing, tooth build up, prophylaxis and periodontal evaluations.

i. No Benefits are available for biofeedback training.

j. No Benefits are available for diagnostic arthroscopy.

B. Hearing Services

Benefits are available for diagnosis and treatment of ear disease or injury. Your PCP must find or suspect injury to the ear or a diseased condition of the ear. Otherwise, no Benefits are available. For example, Benefits are available for laboratory hearing tests furnished by a Network Audiologist, provided that you are Referred to the audiologist by your PCP who finds or suspects injury to the ear or a diseased condition of the ear. No Benefits are available for hearing aids except as stated in IV, “Durable Medical Equipment, Medical Supplies and Prosthetics.”

“Covered Services” (Inpatient and Outpatient care) are described throughout Section 7. Cost sharing amounts are shown under parts I and II of your Cost Sharing Schedule.

Except as stated in subsection II “Outpatient Service,” A “Preventive Care,” “Routine hearing exams,” no Benefits are available for routine hearing services to determine the need for hearing correction.

C. Infertility Diagnostic Services

Benefits are available for diagnostic services to determine the cause of medically documented infertility. For the purposes of determining Benefit availability, “infertility” is defined as the diminished or absent capacity to create a pregnancy. Infertility may occur in either a female or a male.

Infertility may be suspected when a presumably healthy woman who is trying to conceive does not become pregnant after her uterus has had contact with sperm during 12 ovulation cycles in a period of up to 24 consecutive months, as medically documented. For women over age 35, infertility may be suspected after a woman’s uterus has had contact with sperm during six ovulation cycles in a period of up to 12 consecutive months, as medically documented. Anthem may waive the applicable time limits when the cause of infertility is known and medically documented. Please note that menopause in a woman is considered a natural condition and is not considered “infertility” for the purposes of determining Benefit availability under this health plan.

To be eligible for Benefits, Covered Services must be Medically Necessary and:

- Furnished by your PCP or Network obstetrical/gynecological specialist, or
- Approved in advance by your PCP’s Referral and furnished by a Network Provider.

1. Covered Services. Benefits are available for the following Covered Services to determine the cause of medically documented infertility:

- Medical exams,
- Laboratory tests, including sperm counts and motility studies, sperm antibody tests, cervical mucus penetration tests,
• Surgical procedures, and

• Ultrasound and other imaging exams, such as hysterosalpingography to determine the cause of infertility or to establish tubal patency.

Covered Services may be provided to male or female Members. Coverage is not available to partners who are not Members.

Benefits for Covered Services are subject to cost sharing amounts as shown under parts I and II of your Cost Sharing Schedule for medical exams, laboratory and x-ray tests, surgery and anesthesia.

2. Limitations and Exclusions. Except as stated above, no Benefits are available under the terms of this Certificate for any service to diagnose or treat infertility or for any care (Inpatient or Outpatient) related to a noncovered service.

No Benefits are available under any portion of this Certificate for the following services or for any care related to these services:

• Medical exams, consultations and surgical procedures to treat or correct the cause of infertility or to treat or correct medical conditions contributing to infertility,

• Male or female fertility drugs and hormones, and any service to prescribe or monitor the use of fertility drugs or hormones,

• Medical care, sonograms (ultrasounds), laboratory services, radiological services or any other service related to treatment of infertility,

• Egg or sperm procurement, harvesting or processing (including donor services), egg or sperm banking, storage or, microfertilization (egg drilling or tweaking) and electroejaculation procedures,

• Intracervical or intrauterine (IUI) artificial insemination (AI), using the partner’s sperm (AIH) or donor sperm (AID),

• Assisted reproduction technology (ART) such as intravaginal culture, in-vitro fertilization and embryo transfer (IVF-ET) such as natural oocyte retrieval (NORIF or NORIVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT),

• Cryopreservation of donor eggs, cryopreservation of embryos or cryopreserved embryo transfer (CET), intracytoplasmic sperm injection (ICSI), preimplantation genetic diagnosis (PGD),

• To be eligible for Benefits, neither partner can have undergone a previous voluntary or elective sterilization procedure. No Benefits are available for services to reverse voluntarily induced sterility or for diagnosis or treatment following the sterilization or sterilization reversal (successful or unsuccessful),

• Any services or supplies provided to a person not covered under this Certificate in connection with a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple),

• Sex selection, genetic engineering, sperm penetration assays, microvolume straw technique, hamster penetration test (SPA),

• Any infertility procedure performed during an operation not related to an infertility diagnosis,

• Culture and fertilization of oocytes, co-culture of embryos and assisted embryo hatching,
• Direct intraperitoneal insemination (DIPI), peritoneal ovum and sperm transfer (POST),
• Costs related to donor eggs for or from women with genetic oocyte defects, or donor sperm for or from men with genetic sperm defects,
• Supplies (such as thermometers and kits to predict ovulation),
• Menopause in a woman is considered a natural condition and is not considered to be infertility, as defined above. No Benefits are available for infertility diagnosis, procedures or treatment for a woman who is menopausal or perimenopausal (or for their male partners), unless the woman is experiencing menopause at a premature age.
• Except as stated in this subsection, no Benefits are available for any services to diagnose the cause of infertility or to treat infertility. No Benefits are available for any service that is an Experimental/Investigational Service, as defined in Section 8, II “Exclusions.” No Benefits are available for any service that is not Medically Necessary, as defined in Section 14 “Definitions.”

If you have questions about Benefit eligibility for a proposed Infertility Service, you are encouraged to contact Anthem before you receive the service. Your physician should submit a written description of the proposed service to: Anthem Blue Cross and Blue Shield, P.O. Box 660 North Haven, CT 06473-0660. Anthem will review the information and determine in writing whether the requested service is covered or excluded under this Certificate. Anthem’s review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including Copayment, Deductible, and Coinsurance, requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding coverage for Infertility Services. For complete information, please see Section 11 “Member Satisfaction Services and Appeal Procedure.”

D. Organ and Tissue Transplants

To be eligible for Benefits, transplants must be approved in advance according to your PCP’s Referral and Anthem’s Precertification. You and the organ donor must receive services from a Network Provider, Contracting Provider or other Designated Provider, as determined by Anthem. Otherwise, no Benefits are available.

The organ recipient must be a Member. When the organ donor is a Member, and the recipient is a not a Member, no Benefits are available for services received by the donor or by the recipient. Exception: Human leukocyte antigen testing (histocompatibility locus antigen testing) to screen for A, B and DR antigens for the purposes of identifying a Member as a potential bone marrow transplant donor is covered, even if there is no specified recipient at the time of screening and/or an identified recipient is not a Member. This screening for potential donors is covered only if, at the time of the testing:

• The Member who undergoes the screening signs an informed consent form authorizing use of the results for the Member’s participation in the National Marrow Donor Program, and
• The screening is furnished by a Network Provider acting within the scope of the provider’s license.

Otherwise, no Benefits are available for human leukocyte antigen testing to identify potential bone marrow transplant donors when the recipient is not a Member.

Benefits are available only if you meet all of the criteria for transplant eligibility as determined by Anthem and by the provider. The transplant must be generally considered the treatment of choice by Anthem and by the provider. Otherwise, no Benefits are available. Transplants are not covered for patients with certain systemic diseases,
contraindications to immunosuppressive drugs, positive test results for HIV (with or without AIDS), active infection, active drug, alcohol or tobacco use or behavioral or psychiatric disorders likely to compromise adherence to strict medical regimens and post-transplant follow-up.

Covered Services. The following transplants are covered if all of the conditions stated in this subsection are met.

- Cornea, heart, heart-lung, kidney, kidney-pancreas, liver, and pancreas,
- Allogeneic (HLA identical match) bone marrow transplants for acute leukemia, advanced Hodgkin’s lymphoma, advanced non-Hodgkin’s lymphoma, advanced neuroblastoma (for children who are at least one year old), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, Thalassemia major and Wiskott-Aldrich syndrome,
- Autologous bone marrow (autologous stem cell support) transplants and autologous peripheral stem cell support transplants for acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin’s lymphoma, advanced non-Hodgkin’s lymphoma and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Autologous bone marrow transplants are covered for breast cancer consistent with New Hampshire insurance law regarding autologous bone marrow transplants.
- Single or double lung transplants for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension and emphysema. Double lung transplants are covered for cystic fibrosis.
- Small bowel transplants for Members with short bowel syndrome when there is irreversible intestinal failure, an established TPN (total parenteral nutrition) dependence for a minimum of two years, or there is evidence of severe complications from TPN. Simultaneous small bowel/liver transplants are covered for children and adults with short bowel syndrome when there is irreversible intestinal failure, an established TPN dependence for a minimum of two Calendar Years, evidence of severe complications from TPN or evidence of impending end-stage liver failure.

Due to advances in transplant procedures and constantly changing medical technology, Anthem reserves the right to periodically review and update the list of transplant procedures that are Covered Services. For the most up-to-date list of covered transplant procedures, please contact Customer Service. The toll-free telephone number is 1-800-870-3057.

Benefits are available for the tissue typing, surgical procedure, storage expense and transportation costs directly related to the donation of a human organ or other human tissue used in a covered transplant procedure. Benefits are available only to the extent that the costs are not covered by other insurance.

Covered Services (Inpatient and Outpatient) are stated throughout Section 7 “Covered Services.” Covered Services are subject to the cost sharing amounts shown in parts I and II of your Cost Sharing Schedule.

No Benefits are available for any transplant procedure that is not a Covered Service as described in this subsection. Experimental/Investigational transplant procedures and any related care (including care for complications of a non-covered procedure) are not covered except as stated in E, below for “Qualified Clinical Trials.” No Benefits are available for procedures that are not Medically Necessary. No Benefits are available for any service or supply related to surgical procedures for artificial or nonhuman organs or tissues. No Benefits are available for transplants using artificial parts or nonhuman donors. Benefits are not provided for services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to Left Ventricular Assist Devices when used as a bridge to a human heart transplant.
E. Qualified Clinical Trials: Routine Patient Care

Benefits are available for Medically Necessary routine patient care related to drugs and devices that are the subject of clinical trials, provided that all of the following terms and conditions are met:

1. The drug or device under study must be approved for sale by the FDA (regardless of indication).
2. The drug or device under study must be for cancer or any other life-threatening condition.
3. The drug or device must be the subject of a clinical trial approved by one of the following:
   - One of the National Institutes of Health (NIH),
   - An NIH cooperative group or an NIH center,
   - The FDA (in the form of an Investigational new drug application or exemption),
   - The federal department of Veterans Affairs or Defense, or
   - An institutional review board of an institution in New Hampshire that has a multiple assurance contract approved by the Office of Protection from Research Risks of the NIH.
4. Standard treatment has been or would be ineffective, does not exist or there is no superior non-Investigational treatment alternative.
5. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise.
6. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-Investigational alternative.
7. For phase III or IV clinical trials (clinical trials involving leading therapeutic or diagnostic alternatives) Benefits are available for routine patient care, provided that all of the conditions stated in this subsection are met, and subject to all of the other terms and conditions of this Certificate.
8. For phase I or II clinical trials (clinical trials involving emerging technologies), Benefits are available for routine patient care only if:
   - All of the conditions stated in this subsection are met and subject to all of the other terms and conditions of this Certificate, and
   - Anthem reviews all of the information available regarding your individual participation in a Phase I or II clinical trial and determines that Benefits will be provided for your routine patient care. Otherwise, no Benefits are available for routine patient care related to phase I or II clinical trials.

Routine patient care means the Medically Necessary Covered Services described in this Certificate for which Benefits are regularly available, no applicable exclusion is stated in this Certificate and for which reimbursement is regularly made to a Network Provider according to the terms of the provider’s agreement with Anthem. For example, if surgery is Medically Necessary to implant a device that is being tested in a phase III or IV clinical trial, the surgery and any Medically Necessary hospital care are covered according to the terms and conditions of this Certificate. Plan rules and cost sharing rules apply to routine patient care as for any other similar service. Cost sharing amounts for routine patient care costs are shown in the applicable parts of your Cost Sharing Schedule.
example: your share of the cost for Inpatient services is found in section I of the Cost Sharing Schedule and your share of the cost for Infusion Therapy is found in section IV. For Phase I and II clinical trials, Anthem determines Benefit eligibility for routine patient care on a case-by-case basis.

**Routine patient care does not include:**

- The drug or device that the trial is testing,
- Experimental/Investigational drugs or devices not approved for market for any indication by the FDA,
- Non-health care services that a Member may be required to receive in connection with the clinical trial or services that are provided to you for no charge,
- Services that are clearly inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis,
- The cost of managing the research associated with the clinical trial. No Benefits are available for items or services provided primarily to collect data, and not used in the direct provision of Medically Necessary health care services. For example, monthly CT scans for a condition that usually requires fewer scans are not routine patient care,
- Services that are not Medically Necessary, as defined in Section 14 “Definitions,”
- Any service not specifically stated as a Covered Service in this Certificate. Services subject to an exclusion or limitation stated in this Certificate are not routine patient care.

**F. Required Exams or Services**

No Benefits are available for examinations or services that are ordered by a third party and are not Medically Necessary to treat an illness or injury that your physician finds or reasonably suspects. No Benefits are available for examinations or services required to obtain or maintain employment, insurance or professional or other licenses. No Benefits are available for examinations for participation in athletic or recreational activities or for attending a school, camp, or other program, unless furnished during a covered medical exam, as described in Section 7 “Covered Services.”

Court ordered examinations or services are covered, provided that:

- The services are Medically Necessary Covered Services furnished by an Eligible Behavioral Health Provider or another Designated Provider, and
- All of the terms and conditions of this Certificate are met, including network restrictions, Referral and Precertification rules.

Covered Services are subject to the cost sharing amounts as shown under parts I, II and V of your Cost Sharing Schedule.

**G. Surgery**

Benefits are available for covered surgical procedures, including the services of a surgeon, specialist, anesthetist or anesthesiologist and for preoperative and postoperative care.

A Surgical Assistant is a Designated Provider acting within the scope of his or her license who actively assists the operating surgeon in performing a covered surgical service. Benefits are available for the Medically Necessary
services of a Surgical Assistant, provided that:

- The surgery is a Covered Service, and
- The surgery is not on Anthem’s list of surgical procedures that do not require a Surgical Assistant. Anthem’s list is changeable. Please contact your physician or Customer Service before your surgery to obtain the most current information. Anthem’s toll-free telephone number is 1-800-870-3057.

Administration of general anesthesia is covered, provided that:

- The surgery is a Covered Service, and
- The anesthesia is administered by a licensed anesthesiologist or anesthetist who is not the surgeon.

Surgery includes correction of fractures and dislocations, delivery of a baby, endoscopies and any incision or puncture of the skin or tissue that requires the use of surgical instruments to provide a Covered Service. Covered Services are subject to the cost sharing amounts shown under parts I and II of your Cost Sharing Schedule.

Under the terms of this subsection, surgery does not include: inoculation, vaccination, collection of blood or administration or injection of drugs or trigger point injections for treatment of TMJ disorders. Surgery does not include any service excluded from coverage under the terms of this Certificate.

Limitations. In addition to the limitations and exclusions stated elsewhere in this Certificate, the following limitations apply to surgery:

1. **Reconstructive surgery.** Benefits are available for Medically Necessary reconstructive surgery only if at least one of the following criteria is met. **Reconstructive surgery or services must be:**

   - Made necessary by accidental injury; or
   - Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
   - Medically Necessary to restore or improve a bodily function, or
   - Necessary to correct birth defects for covered dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Certificate.
   - Benefits are available for breast reconstruction following mastectomy for patients who elect reconstruction. Breast reconstruction can include reconstruction to both affected breasts or one affected breast. Reconstruction can also include reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast (to produce a symmetrical appearance) in the manner chosen by the patient and the physician.

Reconstructive surgery or procedures or services that do not meet at least one of the above criteria is not covered under any portion of this Certificate.

Provided that the above definition of reconstructive surgery is met, the following reconstructive surgeries are eligible for Benefits:

- Mastectomy for Gynecomastia
- Mandibular/Maxillary orthognathic surgery
- Port wine stain removal
Benefits are available based on the criteria stated in this Certificate. Please see subsection IV, E, “Durable Medical Equipment, Medical Supplies and Prosthetics,” for information about coverage for helmets or adjustable bands used to change the shape of an infant’s head.

Anthem’s definition of Medical Necessity is stated in Section 14.

2. **Cosmetic Services.** Cosmetic Services are not covered under any portion of this Certificate. Please see Section 8 “Limitations and Exclusions,” II “Exclusions” for a definition of Cosmetic Services.

3. **Dental Services.** Dental Services are covered only as stated in A, “Dental Services” (above). Except as stated in A (above), no Benefits are available for Dental Services, including dental surgery, under any portion of this Certificate.

4. **Surgery for conditions caused by obesity.** Benefits are available for bariatric surgery that is Medically Necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity. Anthem’s definition of Medical Necessity is found in Section 14 “Definitions.” When applying the definition of Medical Necessity to bariatric surgery services, Anthem uses standards that are consistent with qualification and treatment criteria set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons.

Surgery to treat the condition of obesity itself or morbid obesity itself is not covered under any portion of this Certificate, even if the surgery, service or program is ordered by your physician or performed or ordered by another Designated Provider. This exclusion applies even if the surgery, service or program meets Anthem’s definition of Medical Necessity. Except as stated in this subsection, no Benefits are available for bariatric surgery or any other surgery intended to manage or control appetite or body weight.

Please see “Diabetes Management Programs” and “Nutrition counseling” in subsection II “Outpatient Services,” A “Preventive Care” and “Outpatient/office visits” in subsection V “Behavioral Health Care (Mental Health and Substance Abuse Care),” B “Covered Services” for information about Benefits for nonsurgical services for weight management, management of obesity and treatment of the diseases and ailments caused by or resulting from obesity.

No Benefits are available for weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

5. **Postoperative medical care.** The Maximum Allowable Benefit for surgery includes the Benefit payment for postoperative medical care. No Benefits beyond the surgical Maximum Allowable Benefit are available for surgery-related postoperative medical care. Please see Section 14 for a definition of the Maximum Allowable Benefit.

6. **Organ/tissue transplant surgery.** Please see subsection D, “Organ and Tissue Transplants” (above in this subsection) for important information about coverage and limitations for organ/tissue transplant surgery.

7. **Intravenous (IV) Sedation and local anesthesia.** The Maximum Allowable Benefit for surgery includes the Benefit payment for IV sedation and/or local anesthesia. No Benefits beyond the surgical Maximum Allowable Benefit are available for IV sedation and/or local anesthesia.

8. **Surgery related to noncovered services.** No Benefits are available for surgery or any other care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services. This exclusion applies even if the service is furnished or ordered by your PCP or other Designated Provider and meets Anthem’s definition of Medical Necessity.
If your proposed surgical services may be considered noncovered reconstructive, cosmetic, dental, weight loss/weight management surgery or if your surgical services may be considered noncovered under other portions of this Certificate, you should contact Anthem before you receive the services. Please ask your physician to submit a written description of the service to: Anthem Blue Cross and Blue Shield, P.O. Box 660 North Haven, CT 06473-0660. Anthem will review the information and determine in writing whether the requested services are covered or excluded under this Certificate. Anthem’s review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including Copayment, Deductible, and Coinsurance, requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.

### H. Vision Services

Benefits are available for *diagnosis and treatment of eye disease or injury*. Covered Services (Inpatient and Outpatient care) are described throughout this Section. Cost sharing amounts are shown under parts I and II of your Cost Sharing Schedule.

To be eligible for Benefits, Network Services must be furnished by your PCP or approved *in advance* according to your PCP’s Referral. Out-of-Network Services are available only if you obtain your PCP’s Referral and Anthem’s Precertification *in advance*. For complete information, please see Section 3 “Access to Care Through Your Primary Care Provider,” IV “Plan Approval for Specialized Care,” “Out-of-Network Services.”

Except for routine vision exams as stated in subsection II, A “Routine vision exams,” or in a rider or endorsement purchased by your Group providing such Benefits, no Benefits are available for *routine* vision care to determine the need for vision correction or for the prescription and fitting of corrective lenses, including contact lenses.
SECTION 8: LIMITATIONS AND EXCLUSIONS

Please see Section 14, “Definitions” for definitions of specially capitalized words.

I. Limitations

The following are important limitations that apply to the Covered Services stated in Section 7, “Covered Services.” In addition to other limitations, conditions or exclusions set forth elsewhere in this Certificate, Benefits for expenses related to the services, supplies, conditions or situations described in this sub-section are limited as indicated below. Limitations apply to these items and services even if you receive them from your PCP or according to a Referral from your PCP.

Please remember, this managed health care plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate. The following list of limitations is not a complete list of all services, supplies, conditions or situations for which Benefits are limited. Limitations are stated throughout this Certificate. If a service is not covered, then all services performed in conjunction with, arising from, or as a result of complications to that service is not covered.

Anthem makes determinations about Referrals, Precertification, Medical Necessity, Experimental/Investigational Services and new technology based on the terms of this Certificate, including the definition of Medical Necessity found in Section 14 “Definitions.” Anthem’s medical policy assists in Anthem’s determinations. Anthem’s medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. For complete information about the appeal process, please see Section 11 “Member Satisfaction Services and Appeal Procedure.”

A. Human Growth Hormones. No Benefits are available for human growth hormones, except:

- To treat children with short stature who have an absolute deficiency in natural growth hormone, or
- To treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.

Benefits are subject to the cost sharing amounts as shown under section II “medical supplies” or section IV, “Infusion Therapy,” depending on the provider of the services. If your Group has purchased a Pharmacy Rider, please see the rider for information about coverage for human growth hormones purchased at a pharmacy for “take-home” use.

B. Private Room. If you occupy a private room, you will have to pay the difference between the hospital's charges for private room and the hospital’s most common charge for a semi-private room, unless it is Medically Necessary for you to occupy a private room. Your PCP must provide Anthem with a written statement regarding the Medical Necessity of your use of a private room, and Anthem must agree in advance that private room accommodations are Medically Necessary. Covered private room charges are subject to the cost sharing amounts as shown under part I of your Cost Sharing Schedule.

C. Ultraviolet Light Therapy and Ultraviolet Laser Therapy for Skin Disorders. Benefits are available for out-of-home ultraviolet light and laser therapy as follows:

- Ultraviolet light therapy is covered for treatment of atopic dermatitis, chronic urticaria, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), pityriasis lichenoides, pityriasis rosea, pruritus of renal failure, psoriasis or vitiligo.
Psoralen with Ultraviolet A light therapy is covered for treatment of acute or chronic pityriasis lichenoides, atopic dermatitis, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), psoriasis and vitiligo.

Ultraviolet laser therapy for the treatment of inflammatory skin disorders such as psoriasis, provided that:

- The inflammation is limited to less than or equal to 10% of the member’s body surface area, and
- The member has undergone conservative therapy with topical agents, with or without standard non-laser ultraviolet light therapy and the conservative therapy was not successful as documented in medical records.

Except as stated in this subsection, no Benefits are available for ultraviolet light or laser therapy for skin disorders.

Please see Section 7 “Covered Services,” IV “Durable Medical Equipment, Medical Supplies and Prosthetics,” for information about coverage for home ultraviolet light therapy for skin disorders. Except as stated in Section 7 “Covered Services” and in this subsection, no Benefits are available for ultraviolet light therapy or ultraviolet laser therapy for skin disorders.

II. Exclusions

No Benefits are available for the following items or services. This subsection is not a complete list of all noncovered services. Other limitations, conditions and exclusions set forth elsewhere in this Certificate. Please remember, this health plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate.

Anthem makes determinations about Referrals, Precertification, Medical Necessity, Experimental/Investigational services and new technology based on the terms of this Certificate, including the definition of Medical Necessity found in Section 14 “Definitions.” Anthem’s medical policy assists in Anthem’s determinations. Anthem’s medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. For complete information about the appeal process, please see Section 11 “Member Satisfaction Services and Appeal Procedure.”

No Benefits are available for the cost of any noncovered services or for the cost of any care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services. The limitations and exclusions found in this subsection of this Certificate and in any other portion of this Certificate apply even if the service is furnished or ordered by your PCP or other Designated Provider and/or the service meets Anthem’s definition of Medical Necessity.

Alternative Medicines or Complementary Medicine. No Benefits are available for alternative or complementary medicine, even if the service is recommended by your physician and even if the services are beneficial to you. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven, established or medically documented or otherwise fails to meet Anthem’s definition of Medical Necessity as stated in Section 14 “Definitions.” Services in this category include acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

Amounts That Exceed the Maximum Allowable Benefit. Benefits for Covered Services are limited to the Maximum Allowable Benefit. As stated in this Certificate and your riders and endorsements, you may be responsible for any amount that exceeds the Maximum Allowable Benefit. See Section 14 for a definition of “Maximum Allowable Benefit.”

Artificial Insemination. In general terms, “artificial insemination” refers to insemination by any means other than natural sexual intercourse. No Benefits are available under any portion of this Certificate for artificial insemination.
Biofeedback Services. Biofeedback services are not covered.

Blood and Blood Products. No Benefits are available for costs related to the donation, drawing or storage of designated blood. Designated blood is blood that is donated and then designated for a specific person’s use at a later date. No Benefits are available for blood, blood donors, blood products or packed red blood cells when participation in a volunteer blood program is available.

Care Furnished by a Family Member. No Benefits are available for care furnished by an individual who normally resides in your household or is a member of your immediate family. Anthem defines your immediate family to include parents, siblings, spouses, children and grandparents.

Care Received When You Are Not Covered Under This Certificate. No Benefits are available for any service that you receive before the effective date of this Certificate.

If an Inpatient admission begins before the effective date of this Certificate and this coverage replaces that of a prior carrier, Benefits will be provided under this Certificate for Inpatient days occurring on or after the effective date of this Certificate, unless the terms of the prior carrier’s Certificate or policy provide coverage for the entire admission (admission date to discharge date), and subject to all of the terms and conditions of this Certificate for Medically Necessary Inpatient services.

Except as stated in Section 13, III “Continuation of Coverage,” Benefits are not available for Inpatient days or any other services that occur after the termination date of coverage under this Certificate.

Care or Complications Related To Noncovered Services. No Benefits are available for the cost of any noncovered services or for the cost of any care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services, except as stated in Section 7 “Covered Services,” VI, A, “Dental Services.” The limitations and exclusions found in this Section and in any other portion of this Certificate apply, even if the service is furnished or ordered by your physician or other Designated Provider and/or the service meets Anthem’s definition of Medical Necessity. Benefits for any complications resulting from noncovered or unauthorized services are excluded from coverage.

Chelating Agents. No Benefits are available for any service, supply or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning.

Convenience Services. No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member’s family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Noncovered Convenience Services include telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of ‘extra’ equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges.

Cosmetic Services. No benefits are available for Cosmetic Services. The cost of care related to, resulting from, arising from or medical condition caused by or providing in connection with Cosmetic Services is not covered. No Benefits are available for care furnished for complications arising from Cosmetic Services. Cosmetic Services include any care, procedure, service, equipment, supplies or medications primarily intended to change your appearance, to improve your appearance or furnished for psychiatric or psychological reasons. For example: surgery or treatments to change the texture or appearance of your skin are not covered. No Benefits are available for surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except for the covered surgery described in Section 7 “Covered Services,” VI, G “Surgery.”

Custodial Care. No Benefits are available for services, supplies or charges for Custodial Care. Custodial Care is not covered, even if the services are furnished or prescribed by a Designated Provider. Custodial Care is primarily for the purpose of assisting you in the activities of daily living and is not specific treatment for an illness or injury. It is care that has minimal therapeutic value and cannot in itself be expected to substantially improve a medical condition. Custodial Care is excluded, even if you receive the care during the course of an illness or injury while
under the supervision of a Designated Provider, and even if the care is prescribed or furnished by a Designated Provider and is beneficial to you. Custodial Care is not covered, whether or not it is furnished in a facility (such as a Short-term General Hospital, Skilled Nursing Facility or Physical Rehabilitation Facility), at home or in another residential setting. Noncovered Custodial Care includes:

- Assistance with walking, bathing, or dressing;
- Oral hygiene, ordinary skin and nail care, maintaining personal hygiene or safety;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Routine maintenance of ostomies;
- Catheter care
- Suctioning;
- Using the toilet;
- Enemas;
- Preparation of special diets;
- Supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel, and
- Domiciliary care. Domiciliary care is care provided in a residential institution or setting, 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. Domiciliary care is Custodial Care and is not covered under any portion of this Certificate.
- Convalescent care. Convalescent care is Custodial Care that you receive during a period of recovery from an acute illness or injury.

**Disease or Injury Sustained as a Result of War or Participation in Riot or Civil Disobedience.** No Benefits are available for care required to diagnose or treat any illness or injury that is a result of war, participation in a riot or other act of civil disobedience.

**Domiciliary Care.** Domiciliary care is care provided in a residential institution or setting, 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. Domiciliary care is Custodial Care and is not covered under any portion of this Certificate.

**Educational, Instructional, Vocational Services and Developmental Disability Services.** Except as stated in Section 7 “Covered Services,” II, A “Diabetes Management Programs,” no Benefits are available for educational or instruction programs or services. Noncovered services include education evaluation, testing, classes, therapy, tutoring, counseling, programs, equipment or supplies. No Benefits are available for vocational/occupational evaluations, testing, classes, therapy, counseling, programs, equipment or supplies. Except as stated in Section 7
“Covered Services,” III, D “Early Intervention Services” and V “Behavioral Health Care,” no Benefits are available for services, counseling, therapy, supplies, equipment or programs for behavioral reasons or for Developmental Disabilities.

**Experimental/Investigational Services.** Except as stated in Section 7 “Covered Services,” VI, E “Qualified Clinical Trials,” Anthem will not pay for Experimental/Investigational Services. No Benefits are available for the cost of care related to, resulting from, arising from or provided in connection with Experimental/Investigational Services. No Benefits are available for care furnished for complications arising from Experimental/Investigational Services.

A. “Experimental or Investigational Service” means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply that is Experimental or Investigational and is used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition.

A drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational if one or more of the following criteria apply when the service is rendered with respect to the use for which Benefits are sought:

- The service cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency and such final approval has not been granted; or

- The service has been determined by the FDA to be contraindicated for the specific use; or

- The service 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

- The service is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- The service is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

B. A service that is not Experimental or Investigational based on the criteria in A (above) may still be Experimental or Investigational if:

- The scientific evidence is not conclusory concerning the effect of the service on health outcomes;

- The evidence does not demonstrate that the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

- The evidence does not demonstrate that 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 does not demonstrate that the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

C. When applying the provisions of A and B (above) to the administration of Benefits under this health plan, Anthem may include one or more items from the following list which is not all inclusive:

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

- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
• Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or

• Documents of an IRB or other similar body performing substantially the same function; or

• Consent document(s) used by the treating 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

• 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.

Anthem uses the terms of this subsection in reviewing services that may be Experimental/Investigational. Anthem’s medical policy assists in Anthem’s review. Anthem’s medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Certificate take precedence over medical policy.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Experimental/Investigational Services. For complete information about the appeal process, please see Section 11 “Member Satisfaction Services and Appeal Procedure.”

**Foot Care, (Routine) Foot Orthotics and Corrective Shoes.** No Benefits are available for routine foot care. Services or supplies in connection with corns, calluses, flat feet, fallen arches, weak feet or chronic foot strain are not covered. No Benefits are available for foot orthotics, inserts or support devices for the feet. Corrective shoes are not covered.

**Free Care.** Benefits are not provided for any care if the care is furnished to you without charge or would normally be furnished to you without charge. This exclusion will also apply if the care would have been furnished to you without charge if you were not covered under this Certificate or under any other health plan or other insurance.

**Health Club Memberships.** No Benefits are available for 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.

**Home Test Kits.** No Benefits are available for laboratory test kits for home use. These include home pregnancy tests and home HIV tests.

**Hospitalization for Noncovered Services.** No Benefits are available for hospital services or any other health care service related to, arising from, the result of, caused by or provided in connection with noncovered services or for complications arising from noncovered services, except as stated in Section 7 “Covered Services,” VI, A, “Dental Services.” No Benefits are available for expenses incurred when you choose to remain in a hospital or another health care facility beyond the discharge time recommended by your physician, or by Anthem.

**Missed Appointments -** Physicians and other providers may charge you for failing to keep scheduled appointments without giving reasonable notice to the office. No Benefits are provided for these charges. You are solely responsible for the charges.
Non-Hospital Institutions - No Benefits are available for care or supplies in any facility that is not specifically stated as a covered facility in this Certificate. No Benefits are available for care or supplies in convalescent homes or similar institutions and facilities that provide primarily custodial, maintenance or rest care. No Benefits are available for care or supplies in health resorts, spas, sanitariums, sanatoriums or tuberculosis hospitals.

Nonmember Biological Parents - No Benefits are available for services received by the biological parent of an adopted child, unless the biological parent is a Member.

Nutrition and/or Dietary Supplements. Except as provided in this Certificate or as required by law, no Benefits are available for nutrition and/or dietary supplements. This exclusion includes 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. Please see Section 7 “Covered Services,” IV, E “Durable Medical Equipment, Medical Supplies and Prosthetics,” for information about Benefits for some of these items. If your Group has purchased a Pharmacy Rider, see your rider for coverage information.

Pharmacy Services. No Benefits are available under this Certificate for prescription drugs purchased at a retail or mail service pharmacy, doctor’s office or facility for “take home” use. Except as specifically stated in this Certificate, no Benefits are available for any drug, medication, supply, equipment, device, service or care furnished by a pharmacy. If your Group has purchased a Pharmacy Rider, please see your rider for information about coverage for services purchased at a pharmacy for “take-home” use.

Premarital Laboratory Work. Premarital laboratory work required by any state or local law is not covered.

Private Duty Nurses. Benefits are not provided for private duty nurses.

Processing Fees. No Benefits are available for the cost of obtaining medical records or other documents that Anthem considers necessary to administer Benefits under this Certificate.

Rehabilitation Services. No Benefits are available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning.

Reversal of Voluntary Sterilization. No Benefits are available for services to reverse voluntarily induced sterility.

Routine Care or Elective Care Outside the Service Area. Benefits are not available for routine care outside the Service Area. Routine care includes routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, immunizations or other preventive care. Elective care is care that can be delayed until you can contact your PCP, Network Provider who specializes in obstetrical/gynecological care or Anthem for direction. Examples of elective care are: scheduled Inpatient admissions or scheduled Outpatient care.

Sclerotherapy for Varicose Veins and Treatment of Spider Veins. Except when treatment is Medically Necessary as defined in Section 14 “Definitions,” no Benefits are available for 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. Treatment of telangiectatic dermal veins (spider veins) by sclerotherapy or any other method is not covered under any portion of this Certificate because such treatment is considered to be cosmetic and not Medically Necessary.

Services Not Covered and Care Related to Noncovered Services. No Benefits are available for services that are not specifically described as Covered Services in this Certificate. No Benefits are available for services that are not covered due to a limitation or exclusion stated in this Certificate. This exclusion applies even if the service meets Anthem’s definition of Medical Necessity and it applies even if a Designated Provider furnishes or orders the service. No Benefits are available for care related to, resulting from, arising from, caused by or provided in
connection with noncovered services or for complications arising from noncovered services. Examples of noncovered services are:

- Services furnished by any individual or entity that is not a Designated Provider, except at the sole discretion of Anthem,
- Services received by someone other than the patient, except as stated in Section 7 “Covered Services,” VI, D “Organ and Tissue Transplants,”
- A separate fee for the services of interns, nurses, residents, fellows, physicians or other providers such as hospital-based ambulance services that are salaried or otherwise compensated by a hospital or other facility,
- The travel time and related expenses of a provider,
- A provider’s charge to file a claim or to transcribe or duplicate your medical records,
- Fees, postage, taxes or other charges for the shipping or handling of covered equipment or services,
- Nonlegend or “over-the-counter” drugs, medications, vitamins, minerals, supplements, supplies or devices.

If your Group has purchased a Pharmacy Rider, please see the rider for information about prescription drugs purchased at a pharmacy for take-home use.

Sex Change Treatment. No Benefits are available for surgical procedures or any other service, drug, product or therapy related to altering your sex from one gender to the other.

Smoking Cessation Drugs, Programs or Services. No Benefits are available for smoking cessation programs, products, drugs or medications, hypnosis, supplies or devices of any kind intended to help you quit smoking or to wean you off nicotine. Such services are not covered, even if administered in a physician’s office, ordered by a physician or if a physician’s written prescription order is required for purchase of the service.

Surrogate Parenting. No Benefits are available for services or supplies provided to a person not covered under this Certificate in connection with a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple.

Transportation. No Benefits are available for transportation costs, except as described in 7, II, “Ambulance Services”.

Unauthorized or NonReferred Care. No Benefits are available for any service that you receive without obtaining a required Referral from your PCP in advance. No Benefits are available for any care related to, resulting from, arising from or provided in connection with the noncovered services or for complications arising from the care. This exclusion applies even if the service is furnished by a Designated Provider and meets Anthem’s definition of Medical Necessity. Except as specified in this Certificate or at Anthem’s discretion, Benefits are available only when Covered services are:

- Furnished by a physician (most often your PCP), or
- Ordered by a physician (most often your PCP) and furnished by a Designated Provider.

Workers’ Compensation - This Certificate does not provide Benefits for any condition, disease, or injury that arises out of or in the course of employment when you are covered by Workers’ Compensation, unless you have waived coverage in accordance with state law.

X-rays. No Benefits are available for diagnostic x-rays in connection with research or study, except as explained for routine patient care costs in Section 7 “Covered Services, VI, E “Qualified Clinical Trials: Routine Patient Care.” No Benefits are available for orthopantagrams.
SECTION 9: CLAIM PROCEDURE

Please see Section 14, “Definitions” for definitions of specially capitalized words.

This Section explains Anthem’s procedure regarding the submission and processing of claims. For the purposes of this Section, Claim Denial means any of the following: Anthem’s denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a member’s eligibility for coverage under this Certificate. Claim Denial also includes Anthem’s denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of Anthem’s utilization review procedures, as well as Anthem’s failure to cover a service for which benefits are otherwise provided based on Anthem’s determination that the service is Experimental, Investigational or not Medically Necessary or appropriate.

I. Post-Service Claims

Post-Service Claims are claims for services that you have received. Post-Service Claims do not include requests for reimbursement made by providers according to the terms of an agreement with Anthem or with a Subcontractor, unless:

- Benefits are reduced or denied, and
- Under the terms of an agreement with Anthem or with a Subcontractor, the provider can bill you for amounts exceeding your Copayment, Deductible and/or Coinsurance.

A. Time Limit for Submitting Post-Service Claims. In order for Anthem make payments for Post-Service Claims, Anthem must receive your claim for Benefits within 12 months after you receive the service. Otherwise, Benefits will be available only if:

- It was not reasonably possible to submit the claim within the 12-month period, and
- The claim is submitted as soon as reasonably possible after the 12-month period.

If services are furnished by an Out-of-Network Provider, you may need to submit your own claim form. Please contact your Group Benefits Administrator or Anthem to obtain the correct claim form as prescribed by Anthem for submission. The toll-free telephone number is 1-800-870-3057. Please complete the claim form, include your itemized bill and any information about other insurance payment and submit the claim to the address indicated on the claim form.

B. Timeframe for Post-Service Claim Determinations. Anthem will make a Post-Service Claim determination within 30 days after receipt of the claim unless you or your authorized representative fail to provide the information needed to make a determination. In the case of such failure, Anthem will notify you within 15 days after receipt of the claim. Anthem’s notice will state the specific information needed to make a determination. You will be provided at least 45 days to respond to Anthem’s notice. The period of time between the date of the request for information and the date of Anthem’s receipt of the information is “carved out” of (does not count against) the 30-day time frame stated in this paragraph.

C. Prompt Payment of New Hampshire Provider Post-Service Claims. In addition to the Post-Service Claim determination rules stated in subsection I “Post-Service Claims,” (above), the following applies to claims for Covered Services furnished by a New Hampshire provider: Claims will be paid according to the terms of New Hampshire law. Clean written claims will be paid within 30 calendar days of receipt. Clean electronic claims will be paid within 15 calendar days of receipt. If Anthem fails to pay an initial claim within the timeframes, Anthem will pay the provider or Member the eligible Benefit for the claim plus an interest payment of 1.5% per month beginning from the date payment was due.
Payment of a claim is considered made on the date the check is issued or electronically transferred. Anthem will mail checks no later than 5 business days after the date of issue.

A “clean claim” is a claim for payment of Covered Services rendered by a New Hampshire provider and meeting the following requirements: The claim is submitted on Anthem’s standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with Anthem’s published filing requirements.

“Electronic claims” means the transmission of data for the purpose of payment of claims for Covered Services furnished by a New Hampshire provider, the claim being submitted in an electronic data format specified by Anthem.

If payment is denied or delayed, Anthem will notify the provider or Subscriber within 15 calendar days of receipt. The notice will include the reason for denial or delay and an explanation of any additional information needed to complete processing. Anthem will adjudicate the claim within 45 calendar days of receipt of the additional information. If the notice of denial or delay is not made as required, the claim will be subject to the timeframes for clean claims stated above in this subsection.

II. Pre-Service Claims

Certain services are covered in part or in whole only if you request and obtain Precertification or Preauthorization in advance from Anthem. Requests for Precertification and Preauthorization, submitted under the terms of this Certificate, are Pre-Service Claims. Pre-Service Claims do not include requests for reimbursement made by providers according to the terms of their agreements with Anthem or a Subcontractor.

Pre-Service Claims may be non-urgent or urgent.

An example of a non-urgent Pre-Service Claim is a request for Precertification of a scheduled Inpatient admission for elective surgery.

Urgent Care Claim means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent Pre-Service Claim determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the proposed care or treatment.

A. Time Limit for Submitting Pre-Service Claims. Unless it is not reasonably possible for you to do so, Pre-Service Claims must be submitted within the applicable time frames stated in this Certificate or in any riders or endorsements that amend this Certificate. For example, as stated in Sections 1 and 6, you must request Precertification within 48 hours after an Emergency Inpatient admission.

B. Timeframes for Making Pre-Service Claim Determinations. Anthem will make a determination about your Pre-Service Claim within the following time frames. Time frames begin when your claim is received and end when a determination is made.

- For non-Urgent Claims a determination will be made within a reasonable time period, but in no more than 15 days after receipt of the claim. Exception: the initial 15 day period may be extended one time for up to 15 additional days, provided that Anthem finds that an extension is necessary due to matters beyond the control of Anthem. Before the end of the initial 15 day period, you will be notified of the circumstances requiring an extension. The notice will also inform you of the date by which a decision will be made. If the extension is necessary because you or your authorized representative failed to provide the information needed to make a determination, the notice of extension will specify the additional information needed. You will be given at least 45 days from receipt of the notice to provide the specified information. The
determination will be made as soon as possible, but in no case later than 15 days after the earlier of 1) receipt of the specified information by Anthem, or 2) the end of the period afforded to you to provide the specified information.

- For Urgent Care Claims a determination will be made as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim. Exception: If you or your authorized representative fail to provide the information needed to make a determination, Anthem will notify you within 24 hours after receipt of the claim. The notice will include the specific information necessary to make a determination. You will be given no less than 48 hours to provide the information. The determination will be made as soon as possible, but in no case later than 48 hours after the earlier of 1) receipt of the specified information by Anthem or 2) the end of the period afforded to you to provide the specified information.

**For Urgent Care Claims Relating to both the Extension of an Ongoing Course of Treatment and a Question of Medical Necessity,** a determination will be made within 24 hours of receipt of the claim, provided that you make the claim at least 24 hours before the approved period of time or course of treatment expires.

No fees for submitting a Pre-Service Claim will be assessed against you or your authorized representative. You may authorize a representative to submit or pursue a Pre-Service Claim or Benefit determination by submitting your written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact Customer Service. The toll-free telephone number is 1-800-870-3057.

Exception: For Urgent Care Claims, Anthem will consider a health care professional with knowledge of your condition (such as your treating physician) to be your authorized representative without requiring your written acknowledgment of the representation.

### III. Notice of a Claim Denial

Anthem’s notice of a Post-Service or a Pre-Service Claim Denial will be in writing or by electronic means and will include the following:

A. The specific reason(s) for the determination, including the specific provision of your plan on which the determination is based,

B. A statement of your right to access the internal appeal process and the process for obtaining external review. In the case of an Urgent Care Claim Denial or when the denial is related to continuation of an ongoing course of treatment for a person who has received emergency services, but who has not been discharged from a facility, Anthem will include a description of the expedited review process,

C. If the Claim Denial is based upon a determination that the claim is Experimental/Investigational or not Medically Necessary or appropriate, the notice will include:

1. The name and credentials of Anthem’s Medical Director, including board status and the state(s) where the Medical Director is currently licensed. If a person or other licensed entity making the Claim Denial is not the Medical Director but a designee, the designee’s credentials, board status, and state(s) of current license will be included, and

2. An explanation of the clinical rationale or the scientific judgment for the determination. The explanation will recite the terms of your plan or of any clinical review criteria or internal rule, guideline, protocol or other similar provision that was relied upon in making the denial and how these provisions apply to your specific medical circumstances.

D. If an internal guideline (such as a rule, protocol, or other similar provision) was relied upon in making the Claim Denial, a statement that such guideline was relied upon. A copy of the guideline will be included with the
notice, or you will be informed that a copy is available free of charge upon request.

E. If clinical review criteria were relied upon in making any Claim Denial, the notice will include a statement that such criteria were relied upon. The explanation of any clinical rationale provided under the terms of C, 2. (above) will be accompanied by the following notice: "The clinical review criteria provided to you are used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the Benefits covered under your Certificate."

Anthem will not release proprietary information protected by third party contracts.

### IV. Appeals

For complete information about the appeal procedure, please see Section 11 “Member Satisfaction Services and Appeal Procedure.” The appeal procedure is part of Anthem’s Claim Procedure.

### V. General Claims Processing Information

**Network Provider or BlueCard Provider Services.** When you receive Covered Services from a Network Provider or from a BlueCard Provider, you will not have to fill out any claim forms. Simply identify yourself as a Member and show your Anthem identification card before you receive the care. Network Providers and BlueCard Providers will file claims for you. You pay only the applicable Copayment, Deductible or Coinsurance amount to the Provider when you receive your Covered Services. Eligible Benefits will be paid directly to Network or BlueCard Providers.

**BlueCard Program.** When you obtain health care services through BlueCard outside the geographic area Anthem serves, the amount you pay for Covered Services is calculated on the lower of:

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

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

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

Whether using a Blue Card Provider or a Network Provider, you will always receive the benefit of the lesser of provider charges or the rate the on-site Blue Cross/or Blue Shield Plan has negotiated with its providers.

**Out-of-Network Services.** When you receive a Covered Service from an Out-of-Network Provider in New Hampshire or a nonBlueCard Provider, you may have to fill out a claim form. You can get claim forms from
Anthem’s Customer Service Center. The toll-free telephone number is **1-800-870-3057**. Mail your completed claim form to Anthem, along with the original itemized bill.

When you are traveling outside the country, you should obtain itemized bills translated to English. Charges for Covered Services should be stated in terms of United States currency. To determine the United States currency amount, please use the exchange rate, as it was on the date you received the care.

Out-of-Network New Hampshire Providers and nonBlueCard Providers may ask you to pay the entire charge at the time of your visit. It is up to you to pay the provider. Generally, Anthem will pay eligible Benefits directly to you. Benefits equal the Maximum Allowable Benefit, minus any applicable Copayment, Deductible or Coinsurance amount. You may be responsible for amounts that exceed the Maximum Allowable Benefit and for the applicable Copayment, Deductible or Coinsurance amounts.

Anthem reserves the right to pay either you or the hospital or any other provider. You cannot assign any Benefits or monies due under this Certificate to any person, provider, corporation, organization or other entity. Any assignment by you will be void and have no effect. Assignment means the transfer to another person, provider, corporation, organization or other entity of your right to the Benefits available under this Certificate.
SECTION 10: OTHER PARTY LIABILITY

Please see Section 14, “Definitions” for definitions of specially capitalized words.

The following guidelines apply to all claims that are submitted for payment under the provisions of Coordination of Benefits (COB), the Medicare Program, Subrogation, Reimbursement and Workers’ Compensation.

1. Coordination of Benefits (COB)

Please Call Customer Service and ask for the coordination of benefits operator if you have questions about any portion of this Section. The toll-free telephone number is 1-800-870-3057.

Please note: You may not hold, or obtain Benefits under both this plan and a nongroup (individual) health insurance policy issued by Anthem or any other insurer.

The following guidelines apply to all claims that are submitted for payment under the provisions of Coordination of Benefits (COB), the Medicare Program, Subrogation, Reimbursement and Workers’ Compensation.

A. Coordination of Benefits (COB).

COB sets the payment responsibilities when you are covered by more than one health care plan or policy. COB is intended to prevent duplication of payment and overpayments for Covered Services furnished to Members. If any Member is covered under another health care plan or policy, Benefits for Covered Services will be coordinated as stated in this Section.

For purposes of this Section only, “health care plan” or “policy” means any of the following, which provide Benefits or services for, or by reason of, medical care or treatment:

- Group or individual hospital, surgical, medical or major medical coverage provided by Anthem Blue Cross and Blue Shield (Anthem), a private insurer or an insurance company, an HMO, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured), a prepayment group or individual practice plan, or a prepayment plan of any other organization. COB applies to any coverage including self-insured, self-funded or unfunded benefit plans or plans administered by a government, such as “socialized medicine” plans. COB also applies to union welfare plans, employee or employer benefit organizations, or any other insurance that provides medical benefits,

- Except as stated in this Section, any insurance policy, contract or other arrangement or insurance coverage, where a health Benefit is provided, arranged or paid, on an insured or uninsured basis,

- Any coverage for students sponsored by, provided through or insured by a school, sports program or other educational institution above the high school level except for school accident type coverage.

For the purposes of this Section, the terms “health care plan” or “policy” do not refer to: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; medical payments coverage in a personal automobile policy, also known as Part B or med pay coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; a state plan under Medicaid; or coverage under other governmental plans, unless permitted by law.

The term “health care plan or policy” will be interpreted separately with respect to:

- Each policy, contract or other arrangement for benefits or services; or
• That portion of any such policy, contract or other arrangement for benefits or services which reserves the right to take the benefits of the other health care plan or policy into consideration in determining its benefits and that portion which does not take such benefits into consideration.

COB also applies when you are covered by more than two policies.

Please remember that your cost sharing amounts (such as Copayments, Deductible, Coinsurance, or annual and lifetime maximums) are your responsibility whether Anthem is the Primary or the Secondary plan. Also, plan rules apply as stated in this Section whether Anthem is the Primary or the Secondary plan. For example, any applicable provider network or participation rules apply and Precertification rules apply.

B. Definitions. The following definitions apply to the terms of this Section:

**Primary** means the health care plan or policy that is responsible for processing your claims for eligible benefits first. When this health care plan is the Primary plan, Anthem will provide the full extent of Benefits for services covered under this Certificate, up to Anthem’s Maximum Allowable Benefit without regard to the possibility that another health care plan or policy may cover some expenses.

**Secondary** means the plan responsible for processing claims for Allowable Expenses after the Primary plan has issued a benefit determination. When this health care plan is Secondary, Benefits under this plan may be reduced so that payments from all health care plans or policies combined do not exceed 100% of the total Allowable Expense.

**Allowable Expense** means a health care service expense that is eligible for Secondary Benefits under this health care plan. Allowable Expenses include any deductible, coinsurance and copayment cost shares required under a Primary plan. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered to be the benefit available under that plan.

The following limitations apply to Allowable Expenses:

• An expense must be for a Medically Necessary Covered Service, as defined in this Certificate. Otherwise, no portion of the expense is an Allowable Expense.

• When the Primary plan has provided full benefits and there is no Member liability for claim payment, no portion of the expense is an Allowable Expense.

• When the Primary plan has provided benefits and there is Member liability for claim payment, the following rules apply to Secondary coverage under this plan:

  a. If all plans covering the claim compute benefits or services based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for the specific claim is not an Allowable Expense.

  b. If all plans covering the claim compute benefits or services based on a negotiated fee, any amount in excess of the highest negotiated fee for the specific claim is not an Allowable Expense.

  c. If one plan computes benefits or services for a claim based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology and another computes benefits or services based on a negotiated fee, the Primary plan's payment arrangement shall be the Allowable Expense for all plans. Exception: If a Network Provider contracts with Anthem to accept a negotiated amount as payment in full when Anthem is the Secondary payer and such negotiated amount differs from the Primary payer’s arrangement, Anthem’s negotiated amount will be the Allowable Expense used to determine Secondary Benefits. The total amount in payments and/or services provided by all payers combined will not exceed Anthem’s Maximum Allowable Benefit.
If the Primary plan bases payment for a claim on the provider’s full charge and does not utilize usual and customary fees, relative value schedule reimbursement methodologies, other similar reimbursement methodologies and does not negotiated fees with providers, the combination of benefits paid by the Primary plan and this plan will not exceed Anthem’s Maximum Allowable Benefit.

The difference between Anthem’s Maximum Allowable Benefit and the provider’s charge is not an Allowable Expense.

When benefits are reduced under a Primary plan due to an individual’s failure to comply with the Primary plan’s provisions, the amount of the reduction is not an Allowable Expense. Examples of these types of plan provisions include managed care requirements for second surgical opinions, Inpatient and Outpatient Precertification requirements and rules about access to care (such as network restrictions and referral rules).

Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

C. The Order of Payment is Determined by COB. COB uses the following rules to determine the Primary and Secondary payers when you are covered by more than one health care plan or policy.

Important General Rules:

- **Medicare Program.** Medicare Secondary Payer (MSP) laws determine whether Medicare benefits will be Primary or Secondary to the Benefits available under this Certificate or any rider, endorsement or other amendment to this Certificate. Factors that determine which plan is Primary include the number of individuals employed by your Group, your status as an active employee, your age and the reason that you are eligible for Medicare. If Medicare is the Secondary plan according to MSP laws, coverage under this Certificate is Primary. If Medicare is the Primary plan according to MSP laws, the Group coverage for which you are eligible is Secondary.

If you are entitled to Medicare benefits when you enroll in this plan, you must inform your Group Benefits Administrator and state this information on your enrollment form. If you become entitled to Medicare benefits after you enroll, you must inform your Group Benefits Administrator and Anthem immediately. You should also contact your local Social Security Office right away to discuss Medicare rules regarding enrollment in Parts A, B and D of Medicare.

- To the extent permitted by applicable law, when any Benefits are available as Primary Benefits to a Member under Medicare or any Workers’ Compensation Laws, Occupational Disease Laws and other employer liability laws, those Benefits will be Primary.

- If you have coverage under this plan and any plan outside the U.S.A. (including plans administered by a government, such as “socialized medicine” plans), the out-of-country plan is Primary when you receive care outside the U.S.A. This plan is Primary when you receive services in the U.S.A. This rule applies before any of the following rules (including the rules for children of separated or divorced parents).

- Except for group coverage that supplements a basic part of a benefit package and provides supplementary coverage (such as major medical coverage superimposed over base hospital/surgical coverage) any health care plan or policy that does not contain a coordination of benefits provision consistent with the terms of this Section is always Primary.

D. Order of Payment Rules. If you are covered by more than one health care plan or policy and none of the rules listed in C (above) apply, the order of benefits will be determined by using the first of the following rules that apply:

- **Non-Dependent/Dependent.** If you are the employee or Subscriber under one policy and you are a dependent under the other, the policy under which you are an employee or Subscriber is Primary. Exception: If you are a Medicare beneficiary and, as a result of federal law, Medicare is Secondary under
the plan covering you as a dependent and Primary to the Plan covering you as an employee or Subscriber, then the order of benefits is reversed so that the plan covering you as an employee or Subscriber is the Secondary plan and the other plan is Primary.

- **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 following “birthday rule” applies:
     a. The plan of the parent whose birthday falls earlier in the Calendar Year is Primary, or
     b. If both parents have the same birthday, the plan that has covered the parent the longest is Primary.

  2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
     a. 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, or
     b. 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 (the birthday rule) shall determine the order of benefits.
     c. 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 (the birthday rule) shall determine the order of benefits.
     d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        (1). The plan covering the Custodial parent;
        (2). The plan covering the spouse of the Custodial parent;
        (3). The plan covering the non-Custodial parent; and then
        (4). The plan covering the spouse of the non-Custodial parent.

     A 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 Year excluding any temporary visitation.
     e. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of 1 or 2 above shall determine the order of benefits as if those individuals were the parents of the child.

- **Active Employee or Retired or Laid-off Employee.** The plan that covers a Member as an active employee (that is - an employee who is neither laid off nor retired) is Primary. The plan covering that same Member as a retired or laid-off employee is Secondary. The same rule applies if a Member is a dependent of an active employee and that same Member is 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 the “Non-Dependent/Dependent” rule (above) can determine the order of benefits.

- **COBRA or State Continuation Coverage.** If a Member is covered under COBRA or a similar “right of continuation” law under either federal or a state law, and the Member is also covered under another policy
that is not a continuation policy, the continuation coverage is Secondary and the other plan is Primary. 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 the “Non-Dependent/Dependent” rule (above) can determine the order of benefits.

- **Longer/Shorter Length of Coverage.** The Plan that covered the person as an employee, Member, policyholder, Subscriber or retiree longer is Primary and the plan that covered the Member the short period of time is Secondary.

- **If the preceding rules do not determine the order of benefits.** Allowable Expenses shall be shared equally between the health care plans or policies. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

### II. Workers’ Compensation

No Benefits are available for any care, condition, disease or injury that arises out of or in the course of employment when you are covered by Workers’ Compensation, unless you or your employer waived coverage in accordance with New Hampshire law.

### III. Subrogation and Reimbursement

These provisions apply when Anthem pays Benefits as a result of injuries, illness, impairment or medical condition you sustain and you have a right to a Recovery or have received a Recovery. For the purposes of this Section, “Recovery” shall mean money you receive from another, the other’s insurer or from any “Home Owner’s,” “Uninsured Motorist,” “Underinsured Motorist,” “Medical-Payments,” “No-Fault,” “Personal Injury Protection” or other insurance coverage provision as a result of injury, illness, impairment or medical condition caused by another or by you. Regardless of how you or your representative or any agreements characterize the Recovery You receive, it shall be subject to the Subrogation and Reimbursement provisions of this Section.

Benefits will be provided for medical care paid, payable or required to be provided under this Certificate, and the Benefits paid, payable or required to be provided. Anthem must be reimbursed by the Member for such payments as permitted under applicable law from medical payments coverage and other property and casualty insurance including homeowners insurance coverage.

Anthem may reduce any Benefit paid, payable or required to be paid under this Certificate by the amount that the Member has received in payment from medical payments coverage and other property and casualty insurance including homeowners insurance coverage.

If benefits are exhausted under a medical payments coverage or other similar property and casualty insurance, Benefits are available under this plan, subject to all of the terms and conditions of this Certificate. Unexhausted medical payments coverage means coverage amounts available in excess of payments made to you or your representative to reimburse your out-of-pocket expenses paid for medical care under this Certificate.

#### A. Subrogation.** If you suffer an injury, illness, impairment or medical condition that is the result of another party’s actions, and Anthem pays Benefits to treat such injury, illness, impairment or medical condition, Anthem will be subrogated to your Recovery rights. Anthem may proceed in your name against the responsible party. Additionally, Anthem shall have the right to recover payments made on your behalf from any party responsible for compensating you for your injury, illness, impairment or medical condition. All of the following shall apply, except to the extent limited by applicable law:

- **Anthem may pursue its subrogation rights for the full amount of Benefits Anthem has 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 Anthem to exercise the rights set forth in this Section and do nothing to prejudice such rights.

• Anthem has the right to take whatever legal action is seen fit against any party or entity to recover Benefits paid under this Plan.

• To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Anthem’s subrogation claim and any claim still held by you, Anthem’s subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

• Anthem is not responsible for any attorney fees, other expenses or costs you incur without the prior written consent of Anthem.

Nothing in this Section shall be construed to limit Anthem’s right to utilize any remedy provided by law to enforce its rights to subrogation under this Section. If you are injured or suffer an impairment or medical condition that is the result of another party's actions, and Anthem pays Benefits to treat such injury or condition, Anthem will be subrogated to your recovery rights. Anthem is entitled to reimbursement from the responsible party or any other party you receive payment from to the extent of Benefits provided. Anthem’s subrogation right includes, but is not limited to underinsured or uninsured motorists’ coverage. By accepting this Certificate, you agree to cooperate with Anthem and do whatever is necessary to secure Anthem’s right and do nothing to prejudice these rights. Anthem reserves the right to compromise on the amount of the claim if Anthem determines that it is appropriate to do so. Any action that interferes with Anthem’s subrogation rights may result in the termination of coverage for the Subscriber and covered dependents.

B. **Reimbursement.** If you obtain a Recovery and Anthem has not been repaid for the Benefits Anthem paid on your behalf, Anthem shall have a right to be repaid from the Recovery up to the amount of the Benefits paid on your behalf. All of the following shall apply, except to the extent limited by applicable law:

• Anthem is entitled to full reimbursement from any Recovery, notwithstanding any allocation made in a settlement agreement or court order, and even if the Recovery does not fully satisfy a judgment, settlement or underlying claim for damages or fully compensate or make you whole.

• You and your legal representative must hold in trust for Anthem 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 Anthem immediately upon your receipt of the Recovery. You must fully reimburse Anthem, without any set-off or reduction for attorney fees, other expenses or costs.

• Anthem shall be entitled to deduct any of the unsatisfied portion of the amount of Benefits paid by Anthem or the amount of your Recovery, whichever is less, from any future Benefits payable by Anthem if:

1. You fail to disclose to Anthem the amount of your Recovery,

2. The amount Anthem paid on your behalf is not repaid or otherwise recovered by Anthem, and/or

3. You fail to cooperate with Anthem.

• Anthem shall also be entitled to recover any of the unsatisfied portion of the amount paid by Anthem or the amount of your Recovery, whichever is less, directly from the providers to whom payments have been made. In such a circumstance, it may then be your obligation to pay the provider the full amount billed by the provider, and Anthem would have no obligation to pay the provider.
IV. Anthem’s Rights Under this Section

Anthem reserves the right to:

- Take any action needed to carry out the terms of this Section, and

- Exchange information with your other insurance company or other party, and

- Recover Anthem’s excess payment from another party or reimburse another party for its excess payment, and

- Take these actions when Anthem decides they are necessary without notifying the Member.

This provision is not intended to permit dissemination of information to persons who do not have a legitimate interest in such information. Neither does this provision permit (in any manner) the dissemination of information prohibited by law.

Whenever another plan or entity pays benefits that should have been made by Anthem in accordance with this Section, Anthem has the right, at its sole discretion, to pay the other plan or entity any amount that Anthem determines to be warranted to satisfy the intent of this Section. Amounts so paid are Benefits under this Certificate and, to the extent of such payments, Anthem is fully discharged from liability under this Certificate.

If Anthem has provided Benefits subject to reimbursement or subrogation and you recover payments from another source which you do not pay to Anthem, Anthem has the right to offset these amounts against any other amount that would otherwise be payable under this Certificate.

Anthem’s recovery rights. On occasion, a payment may be made to you or on your behalf when you are not covered, for a service that is not covered, or which is more than is appropriate for that service. When incorrect payment or overpayment is made, Anthem has the right to recover such payment from any Member, person or entity (including any Member, provider, insurance company or health care plan) to whom or for whom such payment was made. Anthem will notify any Member who is subject to a recovery action. The Member must either remit the required amount to Anthem or provide Anthem with written notice of the reasons the Member may be entitled to such payment. The written notice or recovery amount must be submitted to Anthem within 60 days of Anthem’s recovery notice. If you receive a recovery notice from Anthem and repayment is a financial hardship to you, please ask about an interest free installment plan. Anthem’s mailing address and toll-free telephone number appear on the recovery notice.

V. Your Agreement and Responsibility Under This Section

You have the responsibility to provide prompt, accurate and complete information to Anthem about other health coverages and/or insurance policies or benefits you may have in addition to Anthem coverage. Other health coverages, insurance policies or benefits include benefits from other health coverage, Worker’s Compensation, and/or claims against liability or casualty insurance companies arising from any injury, illness, impairment or medical condition you receive. By accepting this Certificate, you agree to cooperate with Anthem, and you agree to provide information about any other health coverage on an annual basis or when necessary to carry out the terms of this Section.

By accepting this Certificate, you must:

- Promptly notify Anthem of how, when and where an accident or incident resulting in personal injury, illness, impairment or medical condition to you occurred and all information regarding the parties involved,
• Cooperate with Anthem in the investigation, settlement and protection of rights,

• Not do anything to prejudice the rights Anthem,

• Send to Anthem copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury, illness, impairment or medical condition to you, and/or

• Promptly notify Anthem if you retain an attorney or if a lawsuit is filed on your behalf. Any action which interferes with Anthem’s under this Section or the Certificate may result in the termination of coverage for the Subscriber and covered Dependents.
SECTION 11: MEMBER SATISFACTION SERVICES
AND APPEAL PROCEDURE

Please see Section 14, “Definitions” for definitions of specially capitalized words.

This Section explains how to contact Anthem when you have questions, suggestions, concerns or complaints.

I. Member Satisfaction Services

Anthem provides quality member satisfaction services through Customer Service Centers. All personnel are responsible for addressing your concerns in a manner that is accurate, courteous, respectful and prompt. Customer Service Representatives are available to:

- Answer questions you have about your membership, your Benefits, Covered Services, the network, payment of claims, and about policies and procedures,
- Provide information or health plan materials that you want or need (such as health promotion brochures, the network directory, or replacement of identification cards),
- Make sure your suggestions are brought to the attention of the appropriate persons, and
- Provide assistance to you (or your authorized representative) when you want to file an internal appeal.

Your identification number helps to locate your important records with the least amount of inconvenience to you. Your identification number is on your identification card. Please be sure to include your entire identification number (with the three-letter prefix) when you call or write.

Anthem will respond to most of your questions or requests at the time of your call or within a few days. Please see subsection II “Internal Appeal Procedure,” (below) for complete information about the internal appeal procedure. You may have the right to an independent External Review, as summarized under subsection III “External Review Through The New Hampshire Insurance Department,” (below).

If you have a concern about the quality of care offered to you in the network (such as waiting times, physician behavior or demeanor, adequacy of facilities or other similar concerns), you are encouraged to discuss the concerns directly with the provider before you contact a Customer Service Representative.

Please contact Anthem’s Customer Service Center about your membership, Benefits, Covered Services, plan materials, the network or Network Providers. The toll-free telephone number is 1-800-870-3057.

Or, you may write to:
Customer Service Center
Anthem Blue Cross and Blue Shield
P.O. Box 660
North Haven, CT 06473-0660

You may choose to contact the State of New Hampshire Insurance Department for assistance at any time during business hours.
Call the Insurance Department at: 1-800-852-3416

Or, you may write to:
Life, Accident and Health Consumer Affairs Coordinator
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

For more information about Member services, please visit Anthem’s website at www.anthem.com.
II. Internal Appeal Procedure

Introduction. You have the right to receive Benefits for Covered Services, as described in this Certificate. You may appeal any Claim Denial made by Anthem. This section explains the internal appeal procedure.

Please see Section 14 for definitions of “Adverse Determination,” “Claim Denial,” “Urgent Care Claim,” Pre-Service Claim” and “Post-Service Claim”.

Who may submit an internal appeal? You or your authorized representative may submit an internal appeal. A person is an authorized representative if:

- You submit a written statement in a form prescribed by Anthem acknowledging the representation. To find out about required authorization forms, please contact Customer Service. The toll-free telephone number is 1-800-870-3057. Exception: For Urgent Care Claim appeals, Anthem will consider a health care professional with knowledge of your condition (such as your treating physician) to be your authorized representative without requiring your written acknowledgment of the representation, or

- A court order is in effect authorizing the person to act on your behalf and a copy of the order is on file with Anthem.

What should be included with an internal appeal? Please include your identification number (including the three-letter prefix) and describe the services that you are submitting for review. If possible, refer to the date you received the service and state the name of the doctor, hospital or other provider that furnished the care. You may also want to include:

- Bills that you have received from the provider, and

- Any information that you believe is important for review, such as statements from your physician or letters you received from Anthem.

- You may point out the portion of this Certificate that you believe pertains to your appeal. You should state the outcome you are expecting as a result of your appeal.

Anthem may ask you to sign an authorization so that medical records can be obtained to conduct the appeal.

INTERNAL APPEAL PROCESS:

A. You may call or write to initiate an internal appeal. Letters should be addressed to:
   Appeals Department
   Anthem Blue Cross and Blue Shield
   P.O. Box 518, North Haven, CT 06473-0518

Your appeal must be submitted within at least 180 days of Anthem’s notification about the issue that caused you to appeal.

By accepting this Certificate, you agree that the internal appeal procedure provides that one mandatory level of internal appeal is available to you. Your obligation to follow the mandatory appeal procedure is fulfilled when:

- The internal appeal is completed, or

- You seek External Review of an Adverse Determination before the internal appeal is complete, in keeping with the terms of subsection III “External Review Through the New Hampshire Insurance Department,” (below).

B. Time Frames for Internal Appeal Determinations. Anthem will complete the internal appeal process within the following time frames, unless you and Anthem agree mutually to extend the time frames. Time frames begin when
your appeal is received (whether or not all of the necessary information is contained in the filing) and end when notice of the claim determination is issued to you.

- **Expedited Appeals.** An expedited appeal procedure is available for Urgent Care Claim Denials, or Claim Denials concerning an admission, availability of care, continued stay or health care service for Members who have received emergency services, but who have not been discharged from a facility. You may submit information to support your appeal by telephone, facsimile or other expeditious method. Anthem will make a decision and notify you as expeditiously as your medical condition requires, but in no event more than 72 hours. If an initial notice of the determination is not in writing, a written confirmation of the decision will be provided to you within two business days.

If you or your authorized representative fail to provide the information needed to make a determination, Anthem will notify you within 24 hours after receipt of your appeal.

Ongoing Urgent Care services will be continued as directed by your physician without liability to you until you are notified. You will be held harmless for the cost of the care under review, pending the outcome of the internal appeal procedure. This provision applies only to services that are stated as Covered Services in this Certificate. This provision does not waive your cost sharing amounts (such as Copayments, Deductible or Coinsurance) or exclusions stated in this Certificate. If the internal appeal procedure results are adverse to you, you may be responsible for paying the cost of noncovered services, according to the terms and conditions of this Certificate. Expedited Appeals are not available for Post-Service Claims.

- **Nonexpedited Pre-Service Claim Appeals.** Anthem will make a decision and notify you within a reasonable time appropriate to your medical circumstances, but in no event more than 30 days.

- **Post-Service Claim Appeals.** Anthem will make a decision and notify you within a reasonable time appropriate to your medical circumstances, but in no event more than 30 days.

**Please note:** You may be eligible for an independent External Review overseen by the New Hampshire Insurance Department before completing the internal appeal process. Please see subsection III “External Review Through the New Hampshire Insurance Department,” (below) for more information.

**C. Content of Notice of an Appeal Determination.** You will be notified in writing of the appeal determination. If the denial of Benefits is upheld, in whole or in part, the written notice will include the following:

- The specific reason(s) for the determination, including reference to the specific provision of this Certificate or plan on which the determination is based,

- If an internal rule, guideline, protocol or other similar provision was relied upon in making the claim denial, a statement that such a rule, guideline, protocol or other similar provision was relied upon,

- If the determination is based upon a finding that the service under appeal is Experimental, Investigational or not Medically Necessary or appropriate, the notice will include:
  
  - The name and credentials of the person reviewing the appeal, including board status and the state or states where the person is currently licensed, and
  
  - An explanation of the clinical rationale for the determination. This explanation will recite the terms of this Certificate or of any clinical review criteria or any internal rule, guideline, protocol, or other similar provision that was relied upon in making the denial and how these provisions apply to your specific medical circumstance, and
  
  - A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (such as copies of rules, guidelines, protocols
or other similar criterion upon which the Claim Denial is based) relevant to your claim for Benefits. The records on file with Anthem may be limited in scope. Please contact your physician if you have questions or concerns about the content of your medical records, and

- A statement describing all other dispute resolution options available to you, including, but not limited to your options for internal review, external review or for bringing a legal action,

- If the appeal involves an Adverse Determination, a copy of the Insurance Department’s Managed Care Consumer Guide to External Appeal will be included with the notice. The guide includes the specific requirements for filing an External Review. Please see subsection III “External Review Through the New Hampshire Insurance Department,” (below) for more information about External Review.

- Appeal determination notices will remind you that you have the right to contact the Insurance Commissioner’s office for assistance. The Insurance Commissioner’s address and toll-free telephone number will be included in Anthem’s notice.

D. **Full and Fair Review.** Anthem conducts and oversees internal appeals. No fees for submitting an appeal will be assessed against you or your authorized representative. Please note that oral statements by agents or representatives of Anthem do not change the Benefits described in this Certificate.

The internal appeal procedure provides for a full and fair review, as required by New Hampshire law. For example:

- The person(s) reviewing your appeal will not be the same person(s) who made the initial Claim Denial or a subordinate or supervisor of the person who made the initial Claim Denial,

- In the appeal of a Claim Denial based in whole or in part on a medical judgment, including determinations with regard to whether a service is Experimental, Investigational or not Medically Necessary or appropriate, the appeal will be conducted by or in consultation with a health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition of health problem in question. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question, in addition to expertise treating similar complications of those problems.

- Also in the appeal of a Claim Denial based in whole or in part on a medical judgment, Anthem’s decision notice will include the titles and qualifying credentials of the person conducting the review. At your request, the identity and qualifications of any medical or vocational expert whose advice was considered in making the initial Claim Denial (without regard to whether it was relied upon) will be provided.

- You have at least 180 days to file an appeal, following receipt of Anthem’s Claim Denial notification,

- You may submit written comments, documents, records, and other information relating to your appeal, without regard to whether those documents or materials were considered in making the initial Claim Denial,

- You will be provided, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to or considered in making the initial Claim Denial,

- Your issue will be considered anew (de novo), as if the issue had not been reviewed before and as if no decision had been previously rendered. All information, documents, and other material submitted for the internal appeal procedure will be considered without regard to whether the information was considered in making a Claim Denial.

*In addition to the internal appeal procedure described above, you may have the right to an External Review arranged through and overseen by the New Hampshire Insurance Department. For complete information about*
You may have the right to an independent External Review of an Adverse Determination. “Adverse Determination” means a decision by Anthem (or by a designated clinical review entity of Anthem, that a scheduled or emergency admission, continued stay, availability of care, or other health care service has been reviewed and does not meet Anthem’s definition of Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Therefore, Benefits are denied, reduced or terminated by Anthem.

External Reviews are arranged through and overseen by the New Hampshire Insurance Department. They are conducted by neutral Independent Review Organizations as certified by the Insurance Department. Anthem pays for the cost of Independent Review Organization services. There is no cost to you for External Review. For complete information (including instructions on how to submit new information for review and time frames for completing an External Review), please see the Insurance Department’s Managed Care Consumer Guide to External Appeal, enclosed with this Certificate. Please note that the Insurance Department offers oversight of standard and expedited External Reviews.

Your decision to seek External Review is a voluntary level of appeal. It is not an additional step that you must take in order to fulfill your internal appeal procedure obligations, as described in subsection II “Internal Appeal Procedure,” above.

A. Eligibility. As described in the Managed Care Consumer Guide to External Appeal, you are eligible for independent External Review, provided that the topic of the review is an Adverse Determination made by Anthem and:

- The service under appeal is a Covered Service and is not subject to an exclusion or an annual or lifetime maximum, as stated in this Certificate. Or, the service would be covered if certain clinical conditions were met and the decision about coverage is therefore an Adverse Determination. (For example, Anthem may determine that a service is Experimental, Investigational or cosmetic and you disagree. Another example is: Anthem may deny coverage for care outside the network because Anthem finds that appropriate care can be provided in the network and you disagree, and

- Your cost for the service, supply or drug that is the subject of the adverse determination is, or is anticipated in a 12-month period to be, equal to or in excess of $400, and

- Your review request is not for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence or other professional fault, and

- You have completed the internal appeal procedure stated in subsection II “Internal Appeal Procedure,” (above) and the final decision is adverse, or

- The time frames stated for completion of the internal appeal procedure are not met, or

- You and Anthem agree to submit the appeal for External Review before the internal appeal procedure is completed.

B. Notice. Anthem will provide complete notice of your rights to an External Review when:

- An internal appeal procedure is completed and the final decision is an Adverse Determination, or

- The time frame for completion of an internal Adverse Determination appeal is not met (our notification will be issued on the day that the time frame expires), or
You and Anthem agree to waive the internal appeal procedure in order to seek External Review and the appeal involves an Adverse Determination.

In addition to other notification requirements stated in subsection II “Internal Appeal Procedure,” above, External Review notices will include the Managed Care Consumer Guide to External Appeal, which contains complete information about rights, responsibilities, restrictions and time frames.

Please note: the Insurance Department’s Request for Independent External Appeal of a Health Care Decision is a form which you must complete and submit to the Insurance Department to initiate an External Review. For expedited External Review, you must submit the Insurance Department’s Certification of Treating Health Care Provider For Expedited Consideration of a Patient’s External Appeal. These forms are found at the end of the consumer guide.

You must submit your Request for Independent External Appeal of a Health Care Decision to the New Hampshire Insurance Department no later than 180 days after the date of Anthem’s notice. Please contact the Insurance Department if you need assistance with the request forms. The telephone number and address are shown in subsection I “Member Satisfaction Services,” above.

C. The Insurance Department’s Guide to External Review Rights. You are encouraged you to read the New Hampshire Insurance Department’s Managed Care Consumer Guide to External Appeal, which is enclosed with this Certificate. The guide contains important information regarding the External Review process and time frames. It explains your rights and responsibilities and those of the Insurance Department, its certified Independent Review Organizations, and Anthem.

When handling a review on an expedited basis, the selected Independent Review Organization will make a decision and notify Anthem and you as expeditiously as your medical condition requires, but in no event more than 72 hours after the expedited external review is requested. If the initial notice was not in writing, written confirmation of the decision will be made to you or your authorized representative and to Anthem within 2 business days of the non-written notice. The written notice will state whether Anthem’s determination is upheld or reversed. The written notice will also include a statement of the nature of your grievance, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law.

If an expedited External Review is conducted during your hospital stay or while you are continuing a course of treatment, your stay or treatment will continue, as directed by your physician. You will be held harmless for the cost of the care under review, pending the determination of the Independent Review Organization. This provision does not waive your cost sharing amounts (such as Copayments, Deductible or Coinsurance) or exclusions stated in this Certificate. If the external review results are adverse to you, you may be responsible for paying the cost of noncovered services, according to the terms and conditions of this Certificate.

The External Review process may terminate only if your External Review request submitted to the New Hampshire Insurance Department includes new information and:

- Anthem reviews the new information, and
- The Adverse Determination is reversed as a result of the reconsideration process.

If the original decision is reversed due to review of new information, Anthem will approve coverage and notify you, the Insurance Department and the Independent Review Organization. In all other circumstances, the Independent Review Organization will notify you, the Insurance Department and Anthem of the External Review outcome. Standard notice will be made in writing within 20 days of the date that the case record is closed. For expedited reviews, notice will most often be made immediately by telephone or fax, followed by written notice.

An Independent Review Organization’s External Review decision is binding on Anthem. It is also binding on you, except to the extent that you have other remedies available under federal or state law.
IV. Voluntary External Reviews Through your Group

Your Group may offer voluntary external review options. You should contact your Group Benefits Administrator or the Department of Labor to find out about voluntary review processes that may be available to you, such as arbitration or civil or legal action.

Your decision to submit a Benefit dispute to a voluntary external review will have no effect on your rights to any other Benefits provided under the terms of this Certificate. However, with the exception of the External Review process described in subsection III “External Review Through the New Hampshire Insurance Department,” above, and any determination of a court of law, the determination of a voluntary external review procedure is not binding on Anthem.

V. Disagreement With Recommended Treatment

Your physician is responsible for determining the health care services that are appropriate for you. You may disagree with your physician’s decisions and you may decide not to comply with the treatment that is recommended by your physician. You may also request services that your physician feels are incompatible with proper medical care. In the event of a disagreement or failure to comply with recommended treatment, you have the right to refuse the recommendations of your physician. In all cases, Anthem has the right to deny Benefits for care that is not a Covered Service or is not Medically Necessary as defined in this Certificate or is otherwise not covered under the terms of this Certificate.
SECTION 12: GENERAL PROVISIONS

Please see Section 14, “Definitions” for definitions of specially capitalized words.

Limitations or Exclusions. This Certificate shall be construed so that a specific limitation or exclusion will override more general Benefit language.

Anthem’s Responsibility For Notifying You About Benefit Changes. If Anthem changes the provisions of this Certificate, your Group will be given reasonable notice before the effective date of the change and you will receive and amendment to this Certificate reflecting any change in your Benefits.

Any notice that Anthem gives to you will be in writing and mailed to you at the address as it appears on Anthem’s records, or, when permitted by applicable law, in care of your Group health plan.

Right to Change the Certificate. No person or entity acting on behalf of Anthem agent has the right to change or waive any of the provisions of this Certificate without the approval of Anthem’s chief executive in New Hampshire.

- Waiver of Certificate Provisions. Neither the waiver by Anthem hereunder of a breach of or a default under any of the provisions of this Certificate, nor the failure of Anthem, on one or more occasions, to enforce any of the provisions of this Certificate or to exercise any right or privilege hereunder, will thereafter be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any of such provisions, rights or privileges hereunder.

- Applicable Law. This Certificate, the rights and obligations of Anthem and Members under this Certificate, and any claims or disputes relating thereto, will be governed by and construed in accordance with the laws of New Hampshire. This Certificate is intended for sale in the State of New Hampshire. Your Certificate is intended at all times to be consistent with New Hampshire law. If New Hampshire laws, regulations or rules require Anthem to provide Benefits that are not expressly described in this Certificate, then this Certificate is automatically amended only to the extent specified by the laws, regulations or rules that are enacted by the State of New Hampshire. Anthem may adjust premium requirements to reflect additional Benefit requirements that are mandated by the State of New Hampshire.

Anthem is not Responsible for Acts of Providers. Anthem is not liable for the acts or omissions by any individuals or institutions furnishing care or services to you.

Right to Develop Guidelines. Anthem, or anyone acting on Anthem’s behalf, shall determine the administration of Benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, Anthem or anyone acting on Anthem's behalf, determines the administration of your Benefits. Anthem makes determinations about Precertification, Medical Necessity, Experimental / Investigational Services, new technology, whether surgery is cosmetic, whether charges are consistent with Anthem’s Maximum Allowable Benefit, whether or not a service is a Covered Service and all other matters concerning administration and operation of this managed health care plan, based on the terms of this Certificate. Anthem develops medical policy and internal administrative guidelines to assist in Anthem’s determinations. However the terms of this Certificate take precedence over internal policies and guidelines. You have the right to appeal Anthem’s determinations, including Adverse Determinations regarding Medical Necessity and related issues. The appeal process is stated in Section 11 “Member Satisfaction Services and Appeal Procedure.”

Anthem, or anyone acting on Anthem's 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 Certificate and other contracts and agreements, to make determinations about questions arising under the Certificate and other contracts and agreements and to make, develop, establish and amend the medical policy, internal guidelines, rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate and other contracts and agreements. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Certificate, Provider
agreements, and applicable state or federal laws. This Certificate shall be construed so that a specific limitation or exclusion will override more general Benefit language.

NOTE: The administration of this Certificate is governed by the insurance laws of the State of New Hampshire.

**Limitation on Benefits of This Certificate.** No person or entity other than Anthem and Members hereunder is or will be entitled to bring any action to enforce any provision of this Certificate against Anthem or Members hereunder, and the covenants, undertakings and agreements set forth in this Certificate will be solely for the benefit of, and will be enforceable only by, Anthem and the Members covered under this Certificate.

**Headings, Pronouns and Cross-References.** Section and subsection headings contained in this Certificate are inserted for convenience of reference only, will not be deemed to be a part of this Certificate for any purpose, and will not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

All pronouns and any variations thereof will be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

In this Certificate, you find “cross-references.” For example, portions of Section 7 “Covered Services” often refer to Section 8, “Limitations and Exclusions.” These cross-references are for your convenience only. Cross-references are not intended to represent all of the terms, conditions and limitations set forth in this Certificate.

**Spendthrift Provision.** The rights to receive Benefits under this health care plan shall not be assignable or subject to attachment or receivership, nor shall it pass to any trustee in bankruptcy or be reached or applied by any legal process.

**Subcontracting.** Anthem may subcontract with specialized organizations or entities to administer portions of this health plan. For example, administration of Anthem’s pharmacy Benefits or Behavioral Health Care Benefits may be managed by a Subcontractor selected by Anthem. Subcontractors may make Benefit determinations and/or perform administrative, claims paying, or customer service duties on Anthem’s behalf.

**Privacy Practices.** Anthem’s practices regarding the protection of personal health information are stated in your “HIPAA Notice of Privacy Practices.” The Notice is included with your Certificate. If you have any questions about the privacy of your personal health information or if you want a copy of the Notice, contact Anthem’s Customer Service department. The toll-free telephone number is 1-800-870-3057.

**Acknowledgment of Understanding.** By accepting this policy, you expressly acknowledge your understanding that this policy constitutes a benefit plan provided through your Group. Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The license permits Anthem and Matthew Thornton Health Plan to use the Blue Cross and Blue Shield service marks in the State of New Hampshire. The Plan is not contracting as an agent of the Blue Cross and Blue Shield Association.

You also acknowledge that you have not accepted this policy based upon representations by any person other than Anthem, and that no person, entity or organization other than Anthem will be held accountable or liable to you for any of Anthem’s obligations created under this policy. These acknowledgments in no way create any additional obligations whatsoever on the part of Anthem other than those set forth in this policy.
SECTION 13: MEMBERSHIP ELIGIBILITY, TERMINATION OF COVERAGE AND CONTINUATION OF COVERAGE

Please see Section 14, “Definitions” for definitions of specially capitalized words.

I. Eligibility

By accepting this Certificate, you agree to give Anthem information that Anthem needs to verify coverage eligibility. Examples of documentation that Anthem may need to decide membership eligibility are: information regarding residency (such as, but not limited to voter registration and vehicle registration or property tax verification), dependent child status, marital status, divorce, legal separation, birth, adoption or court orders regarding health care coverage for your dependent children and verification of your employment status.

Who Is Covered Under This Certificate? You, the Subscriber, are covered under the Certificate. Depending on the type of coverage you selected (“family,” “two person,” or “parent and child”), the following members of your family are also covered:

A. Your Spouse. Your spouse is eligible to enroll unless you are legally separated. Throughout this Certificate, any reference to “spouse” means:

- The individual to whom the Subscriber is lawfully married, as recognized under the laws of the state where the Subscriber lives, and
- The individual with whom the Subscriber has entered into a lawful civil union as recognized under laws that provide same gender couples in lawful civil unions with the same rights, responsibilities and obligations as afforded to lawfully married couples.

Throughout this Certificate any reference to “marriage” means a lawful marriage or lawful civil union. References to legal separation apply to marriage and civil union legal separations. References to divorce apply to the termination of a lawful marriage or lawful civil union.

The Subscriber’s ex-spouse, following legal separation or divorce is not eligible to enroll. Please note that a covered spouse whose coverage would otherwise end due to legal separation or divorce may elect to continue coverage as stated in subsection III “Continuation of Coverage,” A “Continuation for Divorce or Legal Separation,” and B “Continuation of Coverage When Group Coverage Would Otherwise End.”

B. Dependent children. A dependent child is a Subscriber’s child by blood or by law who is under age 26. Dependent children are your natural children, legally adopted children, children for whom you are the legal guardian, stepchildren who are dependent upon the Subscriber for support and children for whom you are the proposed adoptive parent and who have been placed in your care and custody during the waiting period before the adoption becoming final. Foster children and grandchildren are not eligible for coverage unless they meet the definition of a dependent child stated in this amendment.

Membership ends for a covered dependent child on the earlier of:

- The date that any of the eligibility conditions listed above cease to be met, or
- The date upon which the Group ceases to provide coverage to the Subscriber.

C. EXCEPTION:

Unmarried Incapacitated Dependent. Incapacitated Dependents are the Subscriber’s unmarried dependent children who are 26 years old or older and who are mentally or physically incapable of earning their own living on
the date that eligibility under this Certificate would otherwise end due to age. Incapacitated dependents may remain covered as long as their disability continues and as long as they are financially dependent on the Subscriber and are incapable of self-support. Anthem must receive an application for this incapacitated status, and medical confirmation by a physician of the extent and nature of the disability, within 31 days of the date coverage would otherwise end.

Anthem’s Medical Director must certify that your child is incapacitated. Anthem may periodically request that the incapacitated status of your child be recertified. If the child’s disability ends, he or she may elect to continue group coverage as stated in subsection III “Continuation of Coverage,” (below). Or, he or she may elect to enroll in an individual plan offered by the New Hampshire high risk pool, as stated in subsection III “Continuation of Coverage,” (below).

Except as stated below under “When Coverage Begins,” “Special Enrollees,” and “Newborn Children”, membership changes become effective on the date your Group renews its coverage or on a general Group reopening date or on another date determined by your Group and Anthem, provided that a completed enrollment application is received by your Group and Anthem at least 30 days before the effective date (or within a time frame determined by your Group and Anthem).

**When Coverage Begins.** Your coverage begins on the effective date determined by your Group. You should contact your Group Benefits Administrator for information about your effective date. If you are already enrolled, coverage begins for new members of your family on the date they meet the definitions described in this subsection, provided Anthem receives an application within 31 days of eligibility. Otherwise, you must wait until your Group’s next open enrollment period to add the eligible dependent, except as below for “Special Enrollees.”

If you return from full-time active service following a call to active military duty, no Waiting Period applies (a Waiting period is a period of time, if any, that a Group ordinarily requires to pass before the Group’s health plan becomes effective. See Section 14 for the definition of “Waiting Period.” You and eligible family members can reenroll in your Group’s health care plan, provided you apply for reemployment within the time period permitted by the Uniformed Services Employment and Reemployment Act (USERRA). The time period allowed for reemployment depends on the length of your active military duty. To reenroll in your Group’s health care plan, your application must be received within 31 days of your reemployment date. Coverage will be effective on the effective date of your reemployment.

**Special Enrollees.** Ordinarily, employees and eligible dependents who fail to enroll when first eligible cannot enroll until the Group’s subsequent annual renewal date, a general Group reopening or a date determined by the Group and Anthem. Exceptions exist for Special Enrollees as described below. Special Enrollees are employees and/or eligible dependents who did not enroll in a Group’s health care plan (such as the health care plan provided under this Certificate) when first eligible and who experience one of the following events:

- **Loss of eligibility for other coverage.** This event applies when an employee or an eligible dependent loses other public or private health care coverage, provided that the person was covered under the other plan at the time he or she was first eligible to enroll in this plan and he or she declined enrollment in this plan when first eligible. Provided that your Group and Anthem receive a completed enrollment form within 30 days after eligibility for other coverage is lost, this Certificate will become effective on the first day of the month after receipt of the enrollment form. EXCEPTION to the 30-day rule: Please see “Loss of eligibility for coverage under a state Medicaid or child health insurance program” below.

*Please note: “loss of eligibility for other coverage” includes the following events:*

- Voluntary or involuntary termination of the other health care coverage (including exhaustion of coverage under continuation laws, such as COBRA and whether or not such continuation options exist),

- Loss of eligibility due to voluntary or involuntary termination of employment or eligibility,

- Loss of eligibility due to a reduction in work hours,
• Loss of eligibility due to legal separation, divorce, the death of a spouse or a dependent otherwise loses eligibility (for example: a child attains an age that causes him or her to lose eligibility status in another plan, but the child is eligible to enroll in this health care plan), Employer contributions toward the other coverage end (regardless of whether the person is still eligible for the other coverage),

• For a person covered under an individual HMO policy that does not provide benefits to individuals who no longer reside, live or work in the Service Area, loss of eligibility occurs when the individual loses coverage because he or she no longer resides, lives or works in the service area. For a person with group HMO coverage, the same rule applies, provided that there is no other coverage offered by the other health care plan,

• Loss of eligibility because the other plan ceases to offer health care benefits to a class of similarly situation individuals,

• In a multiple-option group plan, an issuer or insurer providing one of the options ceases to operate in the group market (exception: this provision does not apply if the group plan provides a current right to enroll in alternative coverage),

• An individual incurs a claim that meets or exceeds the other plan’s lifetime benefit maximum.

• The employee’s or eligible dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility. Provided that your enrollment process is completed within 60 days after the eligibility is determined, this Certificate will become effective on the first day of the month after receipt of the enrollment form.

• Court ordered enrollment. This event applies when a court has ordered coverage for a spouse or dependent child under an employee's health care plan. Provided that your Group and Anthem receive a completed enrollment form within 30 days after the court order is issued, this Certificate will become effective on the first day of the month after receipt of the enrollment form.

• New dependent due to marriage or civil union. Employees and eligible dependents who are not covered under this health plan may enroll due to lawful marriage or lawful civil union at the same time as the new spouse. Provided that your Group and Anthem receive a completed enrollment form within 30 days of the date of marriage or civil union, this Certificate will become effective on the first day of the month after receipt of the enrollment form.

• New dependent due to birth, adoption or placement for adoption. Employees and/or spouses and other eligible dependents who are not covered under this health plan may enroll at the same time as a newborn child, adopted child or a child placed in your home as the adoptive parent during the waiting period before adoption. Provided that your Group and Anthem receive a completed enrollment form within 30 days of the birth, adoption or placement, this Certificate will become effective on the date of the birth, adoption or placement.

• Eligibility for a state premium assistance program under Medicaid or CHIP. Employees and/or spouses and other eligible dependents who are not covered under this health plan may enroll when the employee or the spouse or an eligible dependent becomes eligible for a subsidy (state premium assistance program) under Medicaid or the Children’s Health Insurance Program (CHIP). Provided that your enrollment process is completed within 60 days after the eligibility is determined, this Certificate will become effective on the first day of the month after receipt of the enrollment form.

Newborn Children. Your newborn child is eligible for Benefits described in this Certificate for up to 31 days from the child’s date of birth, as long as your coverage is in effect during that time. However, you must complete an enrollment form to add the child to your membership as a covered dependent child. The enrollment form must show your child’s name and date of birth. If you do not have a “family” type membership when your child is born, you
must also indicate on the enrollment form that you want to change your type of membership (from “two person” to “family” or from “one person” to “parent/child” or “family”). You can obtain an enrollment form from your employer. To maintain continuous coverage for your newborn, Anthem must receive your enrollment form within 31 days of the child’s birth.

• If your enrollment form is received within 31 days of the child’s birth, your change in membership type will become effective on the first day of the month following the child’s date of birth. If your enrollment form is not received by Anthem within 31 days after birth, your child’s eligibility for Benefits will end at midnight on the 31st day after the date of birth and you will not be able to enroll your child until your Group’s next open enrollment period.

• If your covered dependent child or Student gives birth, your newborn grandchild is eligible for Benefits for up to 31 days from the child’s date of birth. You cannot add the grandchild to your membership unless you adopt or become the legal guardian of the grandchild.

Effective Date for Benefits. The effective date of the Benefits described in this Certificate is determined by your Group. After your coverage under this Certificate begins, Benefits are available according to the coverage in effect on the “date of service.”

• For Inpatient hospital facility charges, the date of Inpatient admission is the date of service. However, for Inpatient professional services (such as Inpatient medical care or surgery furnished by a physician), the date of service is the date you receive the care.

• For professional maternity care (prenatal care, delivery of the baby and post partum care), the date of service is the date of delivery, provided that the total maternity care was furnished by one provider.

• For Outpatient services (such as emergency room visits, Outpatient hospital care, office visits, physical therapy or Outpatient surgery, etc.), the date of service is the date you receive the care.

Persons Not Eligible for Membership. You must meet the eligibility rules of your Group and the terms set forth by Anthem in this Certificate to be eligible for membership.

Membership will not be denied solely due to medical risk factors such as health status, current or past medical conditions (physical or mental), claims experience or receipt of health care services, genetic information, disability or evidence of insurability (including conditions arising out of domestic violence).

Your Responsibility to Notify Anthem About Changes. It is your responsibility to inform your Group and Anthem of changes in your name or address. It is also your responsibility to inform your Group and Anthem if you need to add a Member to your coverage or when a Member is no longer eligible for coverage under your Certificate. Notice requirements regarding continuation coverage election are stated in subsection III “Continuation of Coverage,” below.

Name changes and membership changes must be made through your Group Benefits Administrator. You will be required to sign an enrollment form in order to effect the change. You can mail notices about a change of address to:

Anthem Blue Cross and Blue Shield
P.O. Box 660
North Haven, Connecticut 06473-0660

Please include your identification number (shown on your identification card) whenever you correspond with Anthem.

Disclosing Other Coverage. As another condition of membership, you agree to provide information to Anthem regarding any other health coverage under which you may be entitled to Benefits. Your receipt of Benefits through another health care plan may affect your Benefits under this Certificate. If you or any of your dependents become
elgible for Medicare, contact your Group Benefits Administrator and Anthem immediately. For more information about how Benefits are determined when you are covered under more than one health insurance plan, including Medicare, please see Section 10, “Other Party Liability.”

II. Termination of Coverage

For purposes of this subsection, “you” refers to the Subscriber. Whether the Subscriber or the Group contacts Anthem to effect any of the termination events listed in this subsection, Anthem will administer the terminations if Anthem has knowledge of the qualifying event.

Membership will not be terminated solely due to medical risk factors such as health status, current or past medical conditions (physical or mental), claims experience or receipt of health care services, genetic information, disability or evidence of insurability (including conditions arising out of domestic violence).

PLEASE SEE SUBSECTION III “CONTINUATION OF COVERAGE” BELOW FOR INFORMATION ABOUT HOW TO CONTINUE GROUP COVERAGE AFTER COVERAGE WOULD OTHERWISE END AND FOR OTHER COVERAGE OPTIONS WHEN GROUP COVERAGE ENDS.

When coverage under your Certificate ends, a Certificate of Creditable Coverage will be issued to you. You should present the document to any succeeding carrier whose plan includes a preexisting condition exclusion period. Please call Customer Service if you have questions about Certificates of Creditable Coverage or to request a copy of your Certificate of Creditable Coverage. Anthem’s toll-free telephone number is 1-800-870-3057.

Termination or Renewal. Coverage under this Certificate is effective for a fixed term. At the time of your Group’s anniversary date or at a special open enrollment period, Anthem will renew your coverage at the option of your Group, except for the following reasons:

- Nonpayment of required premiums. Coverage will terminate on a date stated in a notice mailed by Anthem to the Group if Anthem does not receive payment on time from the Group. Cancellation for nonpayment is considered cancellation by the Group and Subscriber, and not by Anthem.

- The Group’s failure to meet Anthem’s minimum employee participation requirements. Notice of cancellation or nonrenewal for failure to meet minimum participation requirements will be delivered to the Group by Anthem, (or mailed to the Group’s most current address, as shown on Anthem’s records) at least 30 days before the effective date of the cancellation or nonrenewal.

- Fraud or intentional misrepresentation on the part of an individual or an individual’s representative or on the part of an employer, employee, dependent or an employee’s representative.

- A small employer is no longer actively engaged in the business that it was engaged in on the effective date of this plan,

- The employer restricts eligibility to participate in the plan based on an applicant’s medical history or otherwise violates applicable law regarding medical underwriting, such as New Hampshire law and federal HIPAA regulations,

- Anthem ceases to offer coverage in the small and/or large employer market, and has provided 180 days prior notification to the New Hampshire Insurance Department of such action and is otherwise in accordance with all of the terms and conditions of New Hampshire law regarding such action.

Except for nonpayment of premium and as otherwise stated above in this subsection, any notice of cancellation or nonrenewal will be delivered to the Group by Anthem or mailed to the Group’s most current address, as shown on Anthem’s records at least 45 days before the Group’s renewal date. Anthem will notify Members of their eligibility
for continuation coverage and eligibility for individual insurance plans as stated in subsection III “Continuation of Coverage” (below). Upon termination of the Group contract, no further Benefits will be provided under this Certificate, except as described in subsection III “Continuation of Coverage” (below).

Please note: Your Group or Anthem may, at the time of renewal, modify the health care plan offered to your Group.

If You Are No Longer a Member of the Group. If your employment or membership in the Group terminates, your coverage will terminate on a date as determined by your Group and Anthem. Please see subsection III “Continuation of Coverage” (below) for information about continuing group coverage and other coverage options.

On Your Death. Your coverage will terminate on the date of your death. Please see subsection III “Continuation of Coverage” (below) for information about how covered surviving spouses and covered dependents can elect to continue group coverage or obtain individual insurance following the death of the Subscriber.

Termination of Your Marriage. If you become divorced or legally separated, your former spouse is eligible to remain on your group coverage for a maximum of 36 months. For more information, please see subsection III “Continuation of Coverage,” A “Continuation for Divorce or Legal Separation” (below).

Termination of a Dependents’ Coverage. A Dependent child’s coverage or an Incapacitated Dependent’s coverage under this Certificate will terminate on the first day of the month following date on which the dependent:

- Marries, or

- No longer meets the age requirement or any other requirement stated in subsection I “Eligibility” above for dependent children, including full and part time students, except for Incapacitated Dependents, or

- No longer meets the eligibility requirements for an Incapacitated Child

The Subscriber must submit an enrollment form indicating the change within 30 days of such change.

Other Situations Under Which This Contract May Terminate. Anthem may terminate this Certificate for one of the following reasons:

- Anthem may not renew a Subscriber’s coverage for fraud committed by the Subscriber or Member in connection with the enrollment form for this Certificate or with any claim filed under this Certificate.

- Anthem may not renew a Subscriber’s coverage upon 30 days advance written notice if an unauthorized person is allowed to use any Member’s identification card or if Subscriber or Member otherwise cooperates in the unauthorized use of such Member’s identification card.

The Subscriber represents that all statements made in his or her enrollment form for membership, and any enrollment forms or enrollment processes for membership of Dependents, are true to the best of his or her knowledge and belief. If a Subscriber furnishes any misleading, deceptive, incomplete, or untrue statement which is material to the acceptance of his or her enrollment process, Anthem may terminate his or her enrollment under this plan (and that of his or her spouse and Dependents), provided that the termination action occurs within two years from the Subscriber’s date of enrollment. If a Subscriber furnishes any fraudulent statements which are material to the acceptance of his or her enrollment process, Anthem may terminate his or her enrollment under this plan (and that of his or her spouse and Dependents) on a date as determined by Anthem following Anthem’s discovery of such fraud. No statement made, for the purpose of obtaining coverage, will void coverage unless it is written in the enrollment form and signed by you, the Subscriber.
III. Continuation of Coverage

This Section explains the options available to you for continuing your Group coverage after the coverage would otherwise end.

Continuation and Conversion Laws. Certain provisions of law affect your rights to continue coverage when group coverage would otherwise end. Examples of such laws are state statutes and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). In general, federal COBRA law applies if your employer had an average of 20 or more benefit-eligible employees during the year. If you have any questions about continuation of group coverage under New Hampshire laws or federal laws, please contact your Group Benefits Administrator immediately.

New Hampshire law allows you to continue coverage when group coverage would otherwise end.

A. Continuation for Divorce or Legal Separation. If you and your spouse are divorced or legally separated while you are a member of a Group Health Plan, your former spouse is eligible to remain on your policy, as an active dependent until the earliest of the following events occurs:
   - Remarriage of the Subscriber;
   - Remarriage of the former spouse;
   - Death of the Subscriber;
   - The 3-year anniversary of the final decree of divorce or legal separation; or
   - Such earlier time as provided by the final divorce decree or legal separation

NOTE: If the covered divorced or legally separated spouse is 55 years old or older, the former spouse may continue coverage until the date that he or she becomes eligible for coverage under another group health care plan, enrolls in Medicare, or first becomes eligible for Medicare after the date of the divorce or legal separation, whichever occurs first.

When one of the above events occurs, your Group Benefit Administrator must notify Anthem of your former spouse’s ineligibility. Your former spouse may be eligible under the State of New Hampshire Continuation provisions described in B, below.

If your Group replaces this coverage with another insurance carrier, your former spouse may be eligible to continue as your active dependent under the replacement policy. Please consult with the replacement carrier for complete information.

B. New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End. This subsection applies if you experience a Continuation Event.

   - If your employer has one benefit-eligible employee, please see C “Options for health coverage after Continuation Ends” (below).
   - You are not an eligible employee or dependent if you were not covered under the group plan at the time of the Continuation Event.
   - You are not an eligible employee or dependent if you are eligible for other group coverage or you are enrolled in Medicare when a Continuation Event occurs. (If you are entitled to Medicare but not enrolled for Medicare benefits at the time of a Continuation Event, you should contact your local Social Security Office immediately for assistance because continuation ends on the first day that you become eligible for Medicare. For the purposes of this article, “eligible for Medicare” means that you are entitled to enroll in Medicare:
     - On a date outside the Medicare open enrollment period without application of the Medicare penalty for late enrollment, or
     - On a date during an open enrollment period, whichever date occurs first.
Continuation Events. Eligible employees and their eligible dependents can elect to continue group coverage under NH law when one of the following events occurs:

- Your employment is terminated for any reason (except gross misconduct),
- Your hours of employment are reduced so that you no longer qualify to participate in your employer health care plan,
- Coverage is reduced or terminated within one year of the date your employer files for protection under the bankruptcy provisions of Title 11 of the United States Code, or
- The eligible employee dies.

Eligible dependents can elect to continue group coverage when one of the following events occurs:

- A dependent child no longer meets Anthem’s definition of a dependent child, dependent student or incapacitated child,
- You (the ex-employee) and your dependents are on an 18 month continuation period and your continuation ends because you enroll in Medicare or you become eligible for Medicare following a Continuation Event.

Continuation Periods. You and your covered dependents may continue coverage for up to 18 months if:

- Your employment is terminated for any reason (except gross misconduct), or
- Your hours of employment are reduced so that you no longer qualify to participate in your group’s health care plan, or
- Coverage is reduced or terminated within one year of the date your employer files for protection under the bankruptcy provisions of Title 11 of the United States Code.

You may continue coverage for up to 29 months if you are disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of a continuation period. (Medicare begins coverage for the disabled at 29 months.) For ease of administration, you should contact your Group and Anthem as soon as possible after you are notified of your disability status by the Social Security Administration.

Your covered surviving spouse may continue coverage for up to 36 months if coverage would otherwise end because of your death. If your surviving spouse is 55 years old or older, he or she may continue coverage until the date that he or she becomes eligible for coverage under another group health care plan, enrolls in Medicare, or first becomes eligible for Medicare after your death, whichever occurs first.

Your covered spouse may continue coverage for up to 36 months if coverage would otherwise end because your spouse is on an 18 month continuation with you and your continuation ends because you enroll in Medicare or you become eligible for Medicare.

Your covered dependent may continue coverage for up to 36 months if coverage would otherwise end because:

- The child no longer meets Anthem’s definition of a covered dependent child, or
- Because of your death, or
- The child is on an 18 month continuation with you and your continuation ends because you enroll in Medicare or you become eligible for Medicare.
Note: If any of the above events occur during an 18 month continuation period, the time spent on the 18 month period counts toward a total of 36 months of continued coverage for your child.

Notifications. Within 30 days of receiving notice from your Group’s Benefit Administrator that you and/or your covered dependent(s) became ineligible for coverage under your group health benefit plan, you and/or your covered dependent(s) will receive a letter from Anthem notifying you and/or your covered dependent(s) of your right to elect to continue coverage.

The letter will contain information about your right to continue coverage, the amount of premium required to continue coverage and the procedure for electing continuation coverage. You will have 45 days from the date of the letter to make your election by notifying the Group Benefit Administrator of your decision to elect coverage. Your Group Benefit Administrator will notify Anthem of your election to continue coverage.

Continuation Premium. The premium for continued coverage will not be more than 102 percent of the premium charged for employees with similar coverage. The initial premium payment must be paid to your employer at the same time as you submit your initial election of coverage. You must pay subsequent premiums and the administrative fee to your employer by the due date, as stated on your invoice. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. You will be notified within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period.

Continuation Ends. Continuation of group coverage ends on the earlier of one of the following events:

- You become eligible for other group coverage (if you enroll in another group health care plan which contains preexisting condition or waiting period limitations, you may continue coverage only until such limitations cease),
- You enroll in Medicare or on the date that you first become eligible for Medicare following a Continuation Event,
- You do not pay the required premium and administrative fee on time, or your employer (or the insurer) terminates all health benefits for all employees.
- The legal time period of your Continuation Event has expired.

C. Options for health coverage after Continuation Ends.

If your group coverage ends for any reason, including the expiration of the legal time period of your Continuation Event, you may convert to an Anthem non-group plan, provided that:

- You have been insured under the group plan for at least 60 days; and
- You are not covered (or eligible for coverage) under another group policy; and
- You apply within 31 days after the termination of the group coverage.

New Hampshire Non-group Conversion – You will be responsible to pay the full premium for the converted non-group policy according to a schedule as invoiced by Anthem.

Individual Insurance Offered by Anthem. Anthem offers individual health insurance to New Hampshire residents. In general, Anthem’s individual policies are offered to residents who are not eligible for other group coverage or Medicare. If you lose group coverage (including loss of coverage when your continuation coverage ends), please contact Anthem for complete information about individual insurance plans. The toll-free telephone number is 1-800-870-3057.
Also available is **Individual Insurance Offered by the New Hampshire High Risk Pool.** New Hampshire provides eligibility for an individual policy of insurance offered by the New Hampshire High Risk Pool without additional pre-existing condition exclusions and without first seeking coverage through another individual insurance plan. The New Hampshire High Risk Pool does not require evidence of insurability. Other requirements may apply. For example, NH residency may be required. For more information contact the New Hampshire High Risk Pool directly at (1-877-888-6447) or visit the plan’s website at [www.nhhealthplan.org](http://www.nhhealthplan.org).

D. **Termination of the entire group health plan (39-week).** If an employer sponsored group health care plan is terminated for all employees for any reason, members who are covered at the time of such termination may elect to continue the benefits of the plan at the same group rate (plus a two percent administrative fee) as follows:

- For up to 39 weeks; *(NOTE: where an individual is already on a continuation coverage, coverage shall continue until it would have expired had the plan not been terminated or for 39 weeks, whichever occurs first.)*,

- Until the required premium is not paid on time, or

- Until the continuing member becomes eligible for benefits under another group plan (including Medicare), *whichever event occurs first.*

Exception: If you enroll in another group health benefit plan while you are continuing coverage under this statute and the new plan contains preexisting condition or waiting period exclusions or limitations, you may continue coverage under this statute only until such limitations cease.

(If your Group canceled coverage with Anthem for all employees because the Group contracted for coverage with another carrier, you are always considered to be eligible for coverage under the new plan and you are not eligible to continue coverage.)

Anthem will send you a written notice explaining your right to continue coverage under this statute within 30 days of the date your group coverage terminated. Our notice will include information about the conditions of coverage and the premiums that you must pay in order to continue coverage. The election period is a period of 31 days from the date of Anthem’s notice. To elect the 39-week extension, you must do both of the following with the election period.

- Notify Anthem in writing that you elect to continue coverage under this statute, and

- Provide the first monthly premium (plus a two percent administrative fee).

**Note:** Our written notice will be presented to you or mailed to you. If mailed, we will use the most current address on file at our office. Provided that you notify us in writing within this additional period and provided that you submit the required payment with your notification, the effective date of your continuation under this law is the group’s cancellation date. (You are responsible for making payments as billed by Anthem for your extension of group coverage under this law. You are not responsible for paying Anthem for any premiums that were the Group’s responsibility prior to the Group’s cancellation date.)

After we receive your written notice of election (and your premium payment plus a two percent administration fee), Anthem will bill you for subsequent payments.

You must pay the required premium and administrative fee to Anthem by the due date, as stated on your invoice. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. Anthem will notify you within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period.

E. **Continuation of Group Coverage Due to Military Service (USERRA).** In the event you are no longer actively at work due to military service in the Armed Forces of the United States, you may elect to continue health
coverage for yourself and your dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. “Military service” means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

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

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

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

F. Total Disability Benefits. Ordinarily, if your Group coverage ends, no further Benefits are available to continue or extend your group coverage under this Certificate except as stated above in this subsection. However, certain New Hampshire regulations provide extension rights for Members with continuous Total Disabilities, even if the Member does not elect to continue coverage as described above. New Hampshire regulations provide for the following:

You are entitled to an extension of the Benefits described in this Certificate when:

- Your group coverage with Anthem ends, and
- You have a continuous Total Disability on the termination date.

If you are entitled to Benefits for a continuous Total Disability existing on the cancellation date, Benefits for that disability will be allowed for up to 12 months beyond the Group’s date of cancellation.

Eligibility for an extension of Benefits for a continuous Total Disability ends when:

- The 12-month continuous Total Disability period ends, or
- Your continuous Total Disability ends, or
- You reach the limit of Benefits available to you under this Certificate, whichever occurs first.

A Member has a continuous Total Disability if:

- The Member is totally disabled from engaging in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and
- The Member is not engaged in any employment or occupation for wage or profit.

You (or someone acting for you) must notify Anthem that you qualify for Total Disability Benefits, as described in this subsection. To do so, please call Customer Service for assistance. The toll-free telephone number is 1-800-870-3057.
Total Disability extensions are not available for services connected to dental or maternity expenses.

Total Disability extensions are available only to Members of fully-insured plans. Members whose plans are fully funded by an employer, trust or other entity should contact the plan’s Group Benefits Administrator for information about coverage for the disability.

G. Strike, Lockout or other Labor Dispute. If your Group pays part or all of the premiums required to maintain coverage under this Certificate and your compensation is suspended or terminated directly or indirectly as the result of a strike, lockout or other labor dispute, you the employee may maintain coverage under this Certificate for up to 6 months from the date your compensation is suspended. You must make premium payments on time directly to your Group during the 6-month period. Your Group must remit your payments to Anthem by the due date, as shown on Anthem’s invoice issued to your Group.

During the 6-month period, your Group coverage cannot be altered or changed except for modifications that can occur upon expiration and renewal of your Group plan and the decreases or increases of the premium rate upon renewal.

Under New Hampshire law, your Group is required to notify you in writing immediately upon suspension or termination of your compensation as the result of a strike, lockout or other labor dispute. Notice must be sent by mail to the address last on record with your Group.

Eligibility for coverage under this subsection ends when the earliest of the following events occurs:

- You become a full-time employee with another employer, or
- Your premiums are not remitted when due. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. You will be notified within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period, or
- 6 months after your compensation is suspended or terminated as the result of a strike, lockout or other labor dispute.

After the 6-month period ends, you, the employee may continue coverage under this Certificate for an additional 12 months as if you originally had elected the rights provided under subsection B, “New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End” and subject to the same conditions stated in B (above). At the end of the additional 12 months, you, the employee shall have the right to convert to an individual policy as described in C, “Options for health coverage after Continuation Ends,” above in this subsection.
SECTION 14: DEFINITIONS

Please see Section 14, “Definitions” for definitions of specially capitalized words.

Adverse Determination means a decision by Anthem (or by a designated clinical review entity of Anthem), that a scheduled or emergency admission, continued stay, availability of care, or other health care service has been reviewed and does not meet Anthem’s definition of Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Therefore, Benefits are denied, reduced or terminated by Anthem.

Anthem (Anthem Blue Cross and Blue Shield) is the trade name of Anthem Health Plans of New Hampshire, Inc. Anthem is a stock corporation licensed in the State of New Hampshire. Anthem underwrites and administers this plan.

Behavioral Health Care means Covered Services provided to treat Mental Disorders and Substance Abuse Conditions as defined in Section 7 “Covered Services,” V “Behavioral Health Care.”

Benefits means reimbursement or payments available for Covered Services, as described in this Certificate.

Birthing Center means an Outpatient facility operating in compliance with all applicable state licensing and regulatory requirements for Birthing Centers. The primary function of a Birthing Center is to provide Outpatient facility services for prenatal care, delivery of a baby and postpartum care for a mother and her newborn. To be eligible for Benefits under this Certificate, a Birthing Center must have a written agreement directly with Anthem or with another Blue Cross and Blue Shield plan to provide Covered Services to Members. Otherwise, no Benefits are available for services furnished by a Birthing Center.

BlueCard Provider means a Designated Provider outside New Hampshire that is not a Network Provider, but has a written payment agreement with the local Blue Cross and Blue Shield Plan.

Calendar Year means a period of time that starts on January 1 and ends on December 31 of any given year.

Certificate means the agreement between a Subscriber and Anthem regarding the terms and limitations of coverage under this managed health care plan. The Certificate includes the Subscriber Certificate (this document), your completed enrollment form (including an electronic enrollment process), your identification card, your Cost Sharing Schedule and any endorsements and/or riders that amend the Subscriber Certificate.

Claim Denial means any of the following: Anthem’s denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a member’s eligibility for coverage under this Certificate. Claim Denial also includes Anthem’s denial, reduction or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of utilization review procedures, as well as failure to cover a service for which benefits are otherwise provided based on a determination that the service is Experimental, Investigational or not Medically Necessary or appropriate.

Contract Year means a period of time that begins on the effective date of the health care plan offered by your Group. The first Contract Year ends the day before your Group’s first annual renewal date. Each subsequent Contract Year begins on your Group’s annual renewal date and ends the day before its next annual renewal date.

Contracting Provider means a Designated Provider that has an agreement with Anthem to provide certain Covered Services to Members. A Contracting Provider is not a Network Provider.

Convenience Services means any service that is primarily for the convenience of a Member, a Member’s family, or a Designated Provider. Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of “extra” equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges. Convenience Services are not covered, as stated in Section 8 “Limitations and Exclusions,” II “Exclusions,” “Convenience Services.”
Covered Service means the services, products, supplies or treatment specifically described as being eligible for Benefits in this Certificate. To be a Covered Service the service, product, supply or treatment must be:

- Medically Necessary or otherwise specifically described as a Covered Service under this certificate, and
- Within the scope of the license of the Designated Provider performing the service, and
- Rendered while coverage under this Certificate is in force, and
- Not Experimental or Investigational or otherwise excluded or limited under the terms of this Certificate, or by any endorsement, rider or amendment to this Certificate.
- The plan rules stated in this Certificate and in any amendment to this Certificate, must be met. Otherwise, a service may not be a Covered Service. Plan rules include rules such as those pertaining to services furnished by Network Providers and requirements about Precertification or Preauthorization from Anthem.

Designated Provider means the following health care providers, each being duly licensed or certified as required by law in the state which regulates their licensure and practice and each acting within the scope of the applicable license or certification: Short Term General Hospitals, Skilled Nursing and Physical Rehabilitation Facilities, facilities for laboratory and x-ray tests and screenings, individuals licensed and certified to interpret laboratory and x-ray tests and screenings, licensed hospital emergency room facilities, Network Urgent Care Facilities, Network Walk-In Centers, ambulatory surgical centers that have a written payment agreement with Anthem or the Blue Cross and Blue Shield plan where the center is located, hemodialysis centers, home dialysis providers and birthing centers that have a written payment agreement with Anthem or the Blue Cross and Blue Shield plan where the birthing center is located, and cardiac rehabilitation programs. Physicians include Doctors of Medicine (MDs) and Advanced Practice Registered Nurses (APRN) acting within the scope of their licenses. Designated Providers also include physician assistants, nurses and nurse-anesthetists. Home health, hospice and visiting nurse association providers and their certified staff members are also Designated Providers. Infusion therapy providers, licensed durable medical equipment, medical supply or prosthetic providers, licensed retail pharmacies, designated licensed mail order pharmacies, licensed ambulance transportation providers, physical, occupational and speech therapists, doctors of osteopathy and doctors of podiatry are Designated Providers. Audiologists, optometrists, nutrition counselors, Network Diabetes Education Providers, Eligible Behavioral Health Providers, Network New Hampshire Certified Midwives (Network NHCMs), dentists and oral surgeons are Designated Providers only to the extent of coverage stated in Section 7 “Covered Services.” Except at the sole discretion of Anthem, no other provider is a Designated Provider. For example, Doctors of Chiropractic are Designated Providers only to the extent stated in Section 7 “Covered Services.” Practitioners such as acupuncturists, electrologists, doctors of naturopathic medicine and any provider of alternative or complimentary medicine are not Designated Providers. School infirmaries are not Designated Providers. Except as specified in Section 7 “Covered Services,” as required by law or by exception at Anthem’s discretion, Benefits are available only when Covered Services are:

- Furnished by a physician, most often your PCP, or
- Ordered by a physician (most often your PCP) and furnished by a Designated Provider.

Developmental Disabilities means chronic mental or physical impairments that occur at an early age, are likely to continue indefinitely, result in substantial functional limitations and require special care and services of lifelong or extended duration. Such disabilities include abnormalities of the neurological and musculoskeletal systems due to congenital chromosomal anomalies or perinatal disorders, any of which may cause mental retardation or delays in mental development as well as abnormalities or delays in motor functioning and development.

Enrollment Date means the first day of coverage under the plan, or, if there is a Waiting Period established by your Group, the first day of the Waiting Period, which is typically the first day of work.

Group means an organization (such as an employer, union, or association) to which you belong, that arranges for your coverage described in this Certificate.
**Group Benefits Administrator** means the person at your company or place of employment who handles health benefits for your Group.

**Home Health Agency** means a state authorized and licensed agency or organization that provides nursing and therapeutic care in the home of the Member. It must maintain permanent records of services provided to its patients, employ a full-time administrator and have at least one Registered Nurse (R.N.) either on the staff or available to it.

**Inpatient** means care received while you are a bed patient in a hospital, Skilled Nursing Facility or Physical Rehabilitation Facility.

**Maximum Allowable Benefit** means the dollar amount available for a specific Covered Service. Anthem determines the Maximum Allowable Benefit for Covered Services that you receive in New Hampshire. Anthem also determines the Maximum Allowable Benefit for approved Covered Services that you receive from a NonBlueCard Provider outside New Hampshire. The local Blue Cross and Blue Shield plan determines the Maximum Allowable Benefit for Covered Services furnished by a BlueCard Provider. Network Providers and BlueCard Providers accept the Maximum Allowable Benefits payment in full.

**Medical Director** means a physician licensed under New Hampshire law, employed by Anthem is responsible for Anthem’s utilization review techniques and methods and their administration and implementation.

**Medically Necessary or “Medical Necessity”** means health care services or products provided to an enrollee for the purposes of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

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

Please note: The fact that a Designated Provider or other health practitioner orders, prescribes, recommends or furnishes health care services or products will not cause the intervention to be automatically considered Medically Necessary. Anthem may consult the Medical Director and/or independent medical specialists, peer review committees, or other health care professionals qualified to make a recommendation regarding the Medical Necessity of any service or product prescribed for a Member.

You have the right to appeal Benefit determinations made by Anthem or its delegated entities, including Adverse Determinations regarding medical necessity. For complete information about the appeal process, please see Section 11 “Member Satisfaction Services and Appeal Procedure.”

**Member** means a Subscriber and any spouse or lawful civil union partner of a Subscriber. “Member” also means any individual who is covered under this Certificate and is the eligible dependent of the Subscriber, the Subscriber’s spouse or the Subscriber’s lawful civil union partner.

**Network Behavioral Health Provider** means a hospital or other Eligible Behavioral Health Provider, as defined in Section 7 “Covered Services,” V “Behavioral Health Care,” who has an agreement with Anthem to make Covered Behavioral Health Care (Mental Health and Substance Abuse) care available to Members.

**Network Birthing Center** means a Birthing Center, as defined above in this Section, that has a written agreement directly with Anthem to provide Covered Services to Members.

**Network Diabetes Education Provider** means a certified, registered or licensed health care expert in diabetes management who has a written agreement directly with Anthem to furnish diabetes counseling and diabetes education to Members.
Network New Hampshire Certified Midwife (NHCM) means an individual who is certified under New Hampshire law and who has a Network written agreement directly with Anthem to provide Covered Services to Members.

Network Nutrition Counselor means a registered dietitian practicing independently or as part of a physician practice or hospital clinic and who has a written agreement directly with Anthem to provide nutrition counseling to Members.

Network Primary Care Provider (PCP) means a Network Provider who has a written agreement with Anthem regarding, among other things, willingness to provide Covered Services to Members as a Primary Care Provider.

Network Provider means any Designated Provider (such as, but not limited to: physicians, specialists, health care professionals, health care practitioners or hospitals) that has a Network written payment agreement with Anthem to provide Covered Services to Members. Network Physicians include Doctors of Medicine (MDs) and Advanced Practice Registered Nurses (APRN) acting within the scope of their licenses.

Network Service means a Covered Service that you receive from a Network Provider.

Network Urgent Care Facility means a licensed hospital’s free-standing facility that provides urgent health services for diagnosis, care and treatment of illness or injury and that has a written payment agreement directly with Anthem to provide such services to Members. Please see Section 6, “Urgent and Emergency Care” for more information about urgent care.

Network Walk-In Center means a licensed free-standing center that provides episodic health services without appointments for diagnosis, care and treatment of illness or injury and that has a written payment agreement directly with Anthem to provide such services to Members.

NonBlueCard Provider means a Designated Provider outside New Hampshire that does not have a written payment agreement with their local Blue Cross and Blue Shield plan.

Out-of-Network Provider means any physician, specialist, health care professional, health care practitioner, pharmacy, hospital or other health care facility or Designated Provider that is not a Network Provider. Providers who have not contracted or affiliated with Anthem’s designated Subcontractor(s) for the services that are Covered Services under this Certificate are also considered Out-of-Network Providers.

Out-of-Network Services means Covered Services that you receive from an Out-of-Network Provider.

Outpatient means any care received in a health care setting other than an Inpatient setting. “Inpatient” is defined above.

Physical Rehabilitation Facility means a state authorized and licensed facility for physical rehabilitation services where short-term active professional care is provided.

Post-Service Claims are claims for services that you have received and which do not meet the definition of “Pre-Service Claim,” stated below. Post-Service Claims do not include requests for reimbursement made by providers according to the terms of their agreement with Anthem unless:

- Anthem reduces or denies Benefits, and
- The provider can bill you for amounts exceeding your Copayment, Deductible and/or Coinsurance under the terms of an agreement with Anthem.

Precertification or “Precertify” Anthem’s written confirmation that a service is Medically Necessary. Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate including Copayment, Deductible, and Coinsurance, requirements and the limitations, exclusions, network restrictions, other party liability rules and membership eligibility rules stated in this Certificate.
**Pre-Service Claim.** Certain services are covered in part or in whole only if you request and obtain Precertification in advance from Anthem. Requests for Precertification submitted as required under this Certificate, are Pre-Service Claims. Pre-Service Claims do not include requests for reimbursement made by providers according to the terms of their agreements with Anthem.

**Referral** means a specific recommendation by a Member’s PCP that the Member should receive evaluation or treatment from a specific Designated Provider. A recommendation from a PCP is a Referral only to the extent of the specific services approved by the PCP on the written Referral form or by other notification methods prescribed by Anthem for use by PCPs. A general statement by a PCP that a Member should seek a particular type of service or provider does not constitute a Referral under this Certificate.

**Service Area** means the State of New Hampshire. The Service Area also includes the cities and towns of Maine, Massachusetts and Vermont whose borders directly adjoin the New Hampshire border.

**Short Term General Hospital** means a health care institution having an organized professional and medical staff and Inpatient facilities that care primarily for patients with acute diseases and injuries with an average patient length of stay of 30 days or less.

**Skilled Nursing Facility** means an institution which is, pursuant to law, in compliance with all applicable state licensing and regulatory requirements and which provides room and board accommodations and 24-hour-a-day nursing care under the supervision of a Physician and/or Registered Nurse (R.N.) while maintaining permanent medical history records.

**Subcontractor.** Anthem may subcontract particular services to organizations or entities called Subcontractors having specialized expertise in certain areas. This may include but is not limited to mental health and/or substance abuse care. Such Subcontractors or subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, or customer service duties on behalf of Anthem.

**Subscriber** means you, the Member to whom this Certificate is issued.

**Urgent Care Claim** means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent Pre-Service Claim determinations:

- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the proposed care or treatment.

**Urgent Care Facility** means a licensed hospital’s free-standing facility that provides urgent health services for diagnosis, care and treatment of illness or injury. Please see Section 6, “Urgent and Emergency Care” for more information about urgent care.

**Waiting Period** means the period of time, if any, that must pass between the Enrollment Date (defined above in this Section) and the date that coverage under your Group’s health plan becomes effective. Waiting Periods are established by your Group and apply when employees and their eligible dependents are first eligible to enroll in the Group’s health plan. For example: An individual is hired on January 1. The Group requires a three-month Waiting Period before the new employee’s health coverage becomes effective. The Enrollment Date is January 1. The Waiting Period is the three-month period between January 1 and April 1. On April 1, the Waiting Period ends and the employee’s health plan coverage becomes effective.

**Walk-In Center** means a free-standing center that provides episodic health services without appointments for diagnosis, care and treatment of illness or injury.

**You, Your and Yours** - Unless specifically stated otherwise, the words "you," "your" and "yours" refer to you, the person to whom this Certificate is issued (the Subscriber) and your covered spouse and covered dependents—collectively the Members.
Matthew Thornton BlueSM

Cost Sharing Schedule

This Cost Sharing Schedule is an important part of your Subscriber Certificate. Please keep this schedule with your Certificate, because it contains important information about coverage and limitations.

<table>
<thead>
<tr>
<th>Cost Sharing Summary</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Visit Copayment</strong></td>
<td>$25 per visit</td>
</tr>
<tr>
<td>Applies each time you visit your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist.</td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Visit Copayment</strong></td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Applies each time you visit a Specialist who is not your Primary Care Provider (PCP) or Network obstetrical/gynecological specialist. This Copayment also applies each time you visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness or injury.</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room Copayment</strong></td>
<td>$250 per visit</td>
</tr>
<tr>
<td><strong>Urgent Care Facility Copayment</strong></td>
<td>$50 per visit</td>
</tr>
<tr>
<td>Applies each time you visit a licensed hospital’s urgent care facility in the Network for diagnosis, care and treatment of illness or injury.</td>
<td></td>
</tr>
<tr>
<td><strong>Standard Deductible</strong></td>
<td>$3,000 per Member, per Calendar Year</td>
</tr>
<tr>
<td></td>
<td>$9,000 per Family, per Calendar Year</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment, Supplies and Prosthetics</strong></td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$100 per Member, per Calendar Year</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Pharmacy Benefit Cost Sharing</strong></td>
<td></td>
</tr>
<tr>
<td>You may purchase up to a 90-day supply of a covered prescription drug at one time, provided that the drug is a Covered Service, the quantity is ordered by your physician and the drug does not require Precertification from Anthem. You may be required to pay more than one Copayment for any fill or re-fill that exceeds a 30-day supply. Please see your Pharmacy Rider for complete information about your share of the cost for Covered Services purchased at a pharmacy.</td>
<td></td>
</tr>
<tr>
<td><strong>At a Retail Pharmacy:</strong></td>
<td></td>
</tr>
<tr>
<td>Tier 1 Copayment</td>
<td>$10</td>
</tr>
<tr>
<td>Tier 2 Copayment</td>
<td>$35</td>
</tr>
<tr>
<td>Tier 3 Coinsurance</td>
<td>30%</td>
</tr>
<tr>
<td><strong>By Mail Order:</strong></td>
<td></td>
</tr>
<tr>
<td>Tier 1 Copayment</td>
<td>$10</td>
</tr>
<tr>
<td>Tier 2 Copayment</td>
<td>$70</td>
</tr>
<tr>
<td>Tier 3 Coinsurance</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Coinsurance Maximum</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$2,500 per Member, per Calendar Year</td>
</tr>
<tr>
<td></td>
<td>$7,500 per Family, per Calendar Year</td>
</tr>
</tbody>
</table>
**Coverage Outline**

The following is an outline of your coverage. Do not rely on this outline alone. Please read your Subscriber Certificate carefully, because important terms and limitations apply.

<table>
<thead>
<tr>
<th>Coverage Outline</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical/Surgical Care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1. Inpatient Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>In a Short Term General Hospital</strong></td>
<td></td>
</tr>
<tr>
<td>(Facility charges for medical, surgical and maternity admissions)</td>
<td></td>
</tr>
<tr>
<td><strong>In a Skilled Nursing Facility (Facility charges)</strong></td>
<td></td>
</tr>
<tr>
<td>Up to 100 Inpatient days per Member, per Calendar Year</td>
<td>Standard Deductible</td>
</tr>
<tr>
<td><strong>In a Physical Rehabilitation Facility (Facility charges)</strong></td>
<td></td>
</tr>
<tr>
<td>Up to 100 Inpatient days per Member, per Calendar Year</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Physician and Professional Services</strong></td>
<td></td>
</tr>
<tr>
<td>(Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests)</td>
<td></td>
</tr>
<tr>
<td>For Skilled Nursing or Physical Rehabilitation Facility admissions:</td>
<td></td>
</tr>
<tr>
<td>Limited to the number of Inpatient days stated above.</td>
<td></td>
</tr>
<tr>
<td><strong>II. Outpatient Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
</tr>
<tr>
<td>Immunizations for babies, children and adults (Including travel and rabies immunizations)</td>
<td></td>
</tr>
<tr>
<td>Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening</td>
<td></td>
</tr>
<tr>
<td>Routine physical exams for babies, children and adults (Including one annual gynecological exam)</td>
<td></td>
</tr>
<tr>
<td>Family planning visits</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Nutrition counseling</td>
<td></td>
</tr>
<tr>
<td>Routine vision exams (One exam each Calendar Year for Members 18 years old and younger; one exam every two years for Members 19 years old and older.)</td>
<td></td>
</tr>
<tr>
<td>Routine hearing exams (One exam each Calendar Year for Members 18 years old and younger.)</td>
<td></td>
</tr>
<tr>
<td>Diabetes management program</td>
<td>Standard Deductible</td>
</tr>
<tr>
<td><strong>Medical/Surgical Care in a Physician’s Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider (in addition to the Preventive Care above)</strong></td>
<td></td>
</tr>
<tr>
<td>Medical exams, consultations, medical treatments, telemicrowave visits and Network Provider services at a Network Walk-In Center</td>
<td>Visit Copayment, or Specialty Visit Copayment</td>
</tr>
<tr>
<td>Injections (including allergy injections)</td>
<td></td>
</tr>
<tr>
<td>Office surgery and anesthesia</td>
<td></td>
</tr>
<tr>
<td>Surgery and anesthesia at an independent ambulatory surgical center</td>
<td>$75 per admission</td>
</tr>
<tr>
<td>Laboratory tests (including allergy testing)</td>
<td>You pay $0</td>
</tr>
<tr>
<td>X-ray tests (including ultrasound)</td>
<td>Standard Deductible</td>
</tr>
<tr>
<td>MRI, CT Scan, chemotherapy, medical supplies and drugs</td>
<td></td>
</tr>
<tr>
<td>Coverage Outline</td>
<td>Your Cost</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Maternity care (prenatal and postpartum visits)</strong></td>
<td>You pay no Visit Copayment or Specialty Visit Copayment for prenatal or postpartum office visits. Your share of the cost for delivery of a baby is the same as shown above for “Inpatient Services” or below under “Outpatient Facility Care”.</td>
</tr>
<tr>
<td>Please see your Subscriber Certificate for information about total maternity care.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital’s Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center (in addition to the Preventive Care above)</strong></td>
<td></td>
</tr>
<tr>
<td>Medical exams and consultations by a physician and telemedicine visits</td>
<td>Visit Copayment or Specialty Visit Copayment</td>
</tr>
<tr>
<td>Operating room for surgery or delivery of a baby</td>
<td></td>
</tr>
<tr>
<td>Physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy</td>
<td></td>
</tr>
<tr>
<td>Hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRI, CT Scan</td>
<td>Standard Deductible</td>
</tr>
<tr>
<td>Facility charges, medical supplies, drugs, other ancillaries, observation</td>
<td></td>
</tr>
<tr>
<td>Laboratory and x-ray tests (including ultrasounds)</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room Visits and Urgent Care Facility Visits</strong></td>
<td></td>
</tr>
<tr>
<td>Use of the emergency room (The Copayment is waived if you are admitted)</td>
<td>Emergency Room Copayment</td>
</tr>
<tr>
<td>Use of a licensed hospital urgent care facility in the Network</td>
<td>Urgent Care Facility Copayment</td>
</tr>
<tr>
<td>Physician’s fee, surgery, MRI, CT Scan, medical supplies and drugs</td>
<td></td>
</tr>
<tr>
<td>Laboratory and x-ray tests</td>
<td>Standard Deductible</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to Medically Necessary emergency transport</td>
<td></td>
</tr>
<tr>
<td><strong>III. Outpatient Physical Rehabilitation Services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Up to 20 visits per Member, per Calendar Year.</td>
<td></td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>Up to 20 visits per Member, per Calendar Year.</td>
<td></td>
</tr>
<tr>
<td><strong>Speech Therapy</strong></td>
<td>Specialty Visit Copayment</td>
</tr>
<tr>
<td>Up to 20 visits per Member, per Calendar Year.</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac Rehabilitation Visits</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td></td>
</tr>
<tr>
<td>• Office visits – Up to 12 visits per Member, per Calendar Year</td>
<td>Standard Deductible</td>
</tr>
<tr>
<td>• Laboratory and x-ray tests furnished by a chiropractor</td>
<td></td>
</tr>
<tr>
<td><strong>Early Intervention Services</strong></td>
<td></td>
</tr>
<tr>
<td>Available from birth to a covered child’s third birthday.</td>
<td></td>
</tr>
<tr>
<td>Limited to $3,200 per Member, per Calendar Year and $9,600 by the child’s third birthday.</td>
<td>Specialty Visit Copayment</td>
</tr>
<tr>
<td>Please see Section 7, “Covered Services,” III in your Certificate for complete information about Benefits for Early Intervention Services for children with Developmental Disabilities or delays. Coverage is provided as required under NH law.</td>
<td></td>
</tr>
<tr>
<td>Coverage Outline</td>
<td>Your Cost</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>IV. Home Care (in addition to the Preventative Care listed in subsection II above)</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td>Visit Copayment or Specialty Visit Copayment</td>
</tr>
<tr>
<td>Medical exams and routine physical exams for babies, children and adults, medical treatments, telemedicine visits</td>
<td></td>
</tr>
<tr>
<td><strong>Injections</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Surgery and anesthesia</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Agency Services</strong></td>
<td>Standard Deductible</td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td>You Pay $0</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td>Standard Deductible</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment, Medical Supplies and Prosthetics</strong></td>
<td>Subject to the DME Deductible and Coinsurance</td>
</tr>
<tr>
<td>V. Behavioral Health Care (Mental Health and Substance Abuse Care)</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient/Office Visits, Telemedicine visits</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Visits</strong></td>
<td></td>
</tr>
<tr>
<td>Unlimited Medically Necessary visits</td>
<td></td>
</tr>
<tr>
<td>A minimum of two visits for diagnosis and three treatment visits are allowed each without clinical review.</td>
<td>Visit Copayment each visit</td>
</tr>
<tr>
<td><strong>Substance Abuse Visits</strong></td>
<td></td>
</tr>
<tr>
<td>Unlimited Medically Necessary visits</td>
<td></td>
</tr>
<tr>
<td><strong>Partial Hospitalization and Intensive Outpatient Treatment Programs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Disorders</strong></td>
<td>Standard Deductible</td>
</tr>
<tr>
<td>Unlimited Medically Necessary care</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse Conditions:</strong></td>
<td></td>
</tr>
<tr>
<td>Medically Necessary care for rehabilitation</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Disorders:</strong></td>
<td></td>
</tr>
<tr>
<td>Unlimited Medically Necessary Inpatient days, as approved by Anthem’s Preauthorization</td>
<td></td>
</tr>
<tr>
<td><strong>Substance Abuse Conditions:</strong></td>
<td>Standard Deductible</td>
</tr>
<tr>
<td>• Medical detoxification days – Medically Necessary Inpatient days.</td>
<td></td>
</tr>
<tr>
<td>• Substance Abuse Rehabilitation – Medically Necessary Inpatient days.</td>
<td></td>
</tr>
<tr>
<td><strong>Scheduled Ambulance Transport</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to Medically Necessary transport from one facility to another</td>
<td></td>
</tr>
</tbody>
</table>
Network Pharmacy Rider

This rider amends your Subscriber Certificate. It is part of your Certificate. Except as stated in this rider, all of the terms of your Certificate apply.

I. Covered Services

Benefits are available for prescription drugs purchased at a Network Pharmacy or Network Specialty Pharmacy. Covered Services must be ordered in writing, by telephone or electronically by a physician who is duly licensed to authorize a prescription order or refill in the ordinary course of his or her professional practice.

Covered Services include, but are not limited to the following:

- Prescription legend drugs which are dispensed pursuant to a prescription order, under federal law or state law, including drugs prescribed for the treatment of pervasive developmental disorder or autism.

- Prescribed insulin and oral diabetes medications. Prescribed diabetic supplies such as blood glucose test strips, lancets and diabetic needles and syringes for diabetic Members. Basic blood glucose monitors are also covered for diabetic Members. Any cost exceeding the Maximum Allowed Amount for a basic blood glucose monitor is not covered. For example, costs for convenience features (such as features that download information to a computer or special portability features) are not covered.

- Prescription legend contraceptive drugs (oral, implantable and injectable)

- Contraceptive devices, such as IUDs and diaphragms. If an IUD is provided in an Outpatient setting, you are eligible for Benefits as described in this rider, provided that you submit a claim form and receipt to Anthem for the IUD.

- Vitamins that require a prescription by law.

- Specialty Medications used to treat rare conditions and advanced diseases.

- Human growth hormones. Benefits are available to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant. Human growth hormones must be authorized in advance by your child’s physician and must be precertified by Anthem. Please call Anthem at 1-800-531-4450 for Precertification.

II. About Special Programs

From time to time Anthem may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, mail order Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain drugs or preferred products for a limited period of time.

Therapeutic Drug Substitution Program - Your pharmacy Benefits include a therapeutic drug substitution program approved by Anthem and managed by the Pharmacy Benefits Management. This is a voluntary program designed to inform Members and physicians about possible alternatives to certain prescribed drugs. The Pharmacy Benefits Management 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.
Half-Tablet Program - Allows Members to pay a reduced Copayment on selected “once daily dosage” medications. It also allows Members to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take “½ tablet daily” of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. This program is strictly voluntary and the Member’s decision to participate should follow consultation with and the agreement of his/her Physician. For more information about this program, call Anthem’s call center or visit Anthem’s website at www.anthem.com.

III. Pharmacy Options

Benefits are available for covered prescriptions when purchased at a Network Pharmacy or Network Specialty Pharmacy. Prescriptions must meet all of the criteria stated in this rider and must be covered as described in “Covered Services” (above). Otherwise, no Benefits are available.

Network Pharmacies and Specialty Pharmacies accept Anthem’s allowable Benefit as payment in full for Covered Services. For a list of pharmacies in the network please visit Anthem’s website www.anthem.com.

You must show your identification card at a Network Pharmacy and Specialty Pharmacy. If you do not show your identification card, you will be required to pay the full cost of the prescription. To obtain reimbursement, a completed claim form must be submitted as directed on the form. Reimbursement is limited to the allowable Benefit, minus your cost sharing (Copayment, Deductible, and/or Coinsurance). The allowable Benefit (contracted discount rate with pharmacy) is the dollar amount available for a specific prescription item.

Please see “Cost Sharing” (below) for more information about your share of the cost.

IV. Cost Sharing

Depending on the plan chosen by your Group, the following types of cost sharing may apply to Covered Services under this rider, as shown on your Cost Sharing Schedule. These are separate cost sharing amounts that do not count toward meeting any other Deductible or Coinsurance Maximum described in your Subscriber Certificate.

Your Deductible, Coinsurance, and/or Copayment will not be reduced by any discounts, rebates or other funds received by the Pharmacy Benefits Management from drug manufacturers, wholesalers, distributors, similar vendors or funds received by Anthem from the Pharmacy Benefits Management.

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

Coinsurance - the percentage of the Maximum Allowed Amount that you pay after your Deductible is met. There may be a limit to the amount of Coinsurance you are required to pay per fill or re-fill as shown on your Cost Sharing Schedule.

Copayment - a fixed dollar amount you pay each time you fill (or refill) a prescription, after any applicable Deductible is met. Your prescription drug Copayment will be the lesser of your scheduled Copayment amount or the retail price charged for your prescription by the pharmacy that fills your prescription.

The Copayment/Coinsurance amount you pay depends on whether the prescription drug has been classified by Anthem as a Tier 1, Tier 2, or Tier 3 drug. Anthem’s determination of a prescription tier is based on:

- clinical information,
- (if appropriate), the cost effectiveness of the drug relative to other drugs in its therapeutic class or use for the treatment of the same or similar condition;
• the availability of an over-the-counter alternative; and
• where appropriate, certain clinical economic factors

The classification of pharmaceutical products is developed in consultation with physicians and pharmacists and approved for their quality and cost effectiveness. If you are affected by a deletion to the prescription drug list, Anthem will notify you at least 45 days before the change is made.

**Tier 1** Copayment generally include generic prescription drugs. Tier 1 prescription drugs have the lowest Coinsurance or Copayment. This tier will contain low cost and preferred medications that may be generic, single source brand drugs, or multi-source Brand drugs.

**Tier 2** Copayment generally include brand name or generic prescription drugs, but may include more costly or newer generic drugs. Tier 2 prescription drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier will contain preferred medications that may be generic, single source brand drugs, or multi-source Brand drugs.

**Tier 3** Coinsurance generally include Brand name or Generic prescription drugs. Tier 3 prescription drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier will contain non-preferred medications that may be generic, single source brand drugs, or multi-source brand drugs and Specialty Medications.

**Note:** to determine the Copayment tier of your prescription, you are encouraged to visit Anthem’s website www.anthem.com. You may also request a copy of the prescription tier drug list by calling Anthem’s Customer Service. The toll free telephone number is listed on your identification card. Or, you may call Anthem at 1-800-874-7122. Please see your Cost Sharing Schedule for information about your cost sharing amounts.

**Copayment amounts apply as follows:**

- You pay one Copayment for each prescription filled (or refilled) up to a 30-day supply.

- At a retail pharmacy, any single fill (or refill) exceeding the 30-day limit requires additional Copayments. For example, a 45-day maintenance medication fill requires two Copayments. A 90-day maintenance medication fill requires three Copayments. Twelve Copayments are required each time you fill a prescription for a prescription device for 12 months.

- You pay one Copayment for each prescription filled (or refilled) up to a 90-day supply through a mail order pharmacy.

- Any single fill (or refill) exceeding the 90-day limit requires additional Copayments. For example, four- Copayments are required each time you fill a prescription for a prescription device for 12 months.

**Important Note:** In addition to your cost sharing described above, If you purchase a Brand name prescription when there is a Generic prescription available, you pay the difference between the Maximum Allowed Amount for the Brand prescription and the Maximum Allowed Amount for the Generic prescription. You pay the difference unless your physician indicates on the prescription order that a Generic substitution is not medically appropriate. For example: the Maximum Allowed Amount of a Brand name prescription is $50. A Generic substitution is available. The Maximum Allowed Amount of the Generic prescription is $40. You pay the $10 difference. The $10 difference is not applied towards any other cost sharing requirement. Any applicable Deductible, Coinsurance and/or Copayment are based on the retail price of the Brand prescription.
V. Limitations

You may purchase up to a 90-day supply of a covered prescription drug at one time, provided that the drug is a Covered Service, the quantity is ordered by your physician and the drug does not require Prior Authorization from Anthem. The following limitations apply to Covered Services under this rider:

- Law regulates supplies of controlled substances. To be eligible for Benefits, they must be purchased at a retail pharmacy. They cannot be purchased from the mail service pharmacy.

- Benefits are available for prescription therapeutic equivalent alternative drugs. Therapeutic equivalent alternative drugs are chemically and therapeutically equivalent to drugs in the same drug category. For the majority of individuals, these drugs can be expected to produce similar clinical outcomes for certain diseases or conditions.

Certain prescription drugs are not covered when a prescription therapeutic equivalent alternative drug is available unless:

- Required by law, or
- The prescription is Medically Necessary, as defined in your Certificate, and
- Your prescribing physician provides Anthem with a written statement that includes the reasons why the use of that prescription drug is more medically beneficial than the therapeutic equivalent alternative drug.

- Benefits are available for Medically Necessary routine patient care costs incurred during a Member’s treatment in accordance with phases I, II, III and/or IV of a qualified clinical trial for cancer or any other life-threatening condition. For the purposes of this rider, routine patient care costs are services that would be Covered Services if you were receiving non-investigational treatment instead of treatment during a qualified clinical trial.

Coverage for routine patient care costs during phase I or II of a clinical trial will be decided by Anthem on a case by case basis. The appeal procedure outlined in your Certificate is available if you disagree with Anthem’s decisions about coverage. Please see Section 8, I, “Experimental/Investigational Procedures and Qualified Clinical Trials” of your Subscriber Certificate for more information.

- Benefits are available for drugs prescribed for off-label use if recognized for treatment of the indication in one of the standard reference compendia; or in the medical literature, as recommended by current American Medical Association policies. However, No Benefits are available for a drug prescribed for off-label use if the FDA has determined its use to be contraindicated for the prescribed use.

- Certain prescription drugs (or the prescribed quantity of a particular drug) require Prior Authorization.

Network Pharmacies are notified about drugs that require prior authorization at the time you fill your prescription. Network pharmacist may contact the Pharmacy Benefits Management at 1-800-338-6180.

If your physician has not obtained Prior Authorization and he/she is not available at the time of dispensing, the network pharmacists will contact the Pharmacy Benefits Management. If clinical information is not required to fill your prescription, the authorization will be approved.

If your physician has not obtained Prior Authorization and he/she is not available at the time of dispensing, the network pharmacists will contact the Pharmacy Benefits Management. If clinical information is required, your prescription may not be immediately filled. The Pharmacy Benefits Management will contact the prescribing physician and respond to your physician within 48 hours of receipt of the supporting clinical rationale.
Out-of-Network Pharmacies are not notified about drugs that require Prior Authorization. If the Pharmacy Benefits Management determines that clinical information is required, your prescribing physician will be required to submit supporting clinical information before your claim can be processed. Anthem will respond to your physician within 48 hours of receipt of the clinical information.

**Important Note:** The authorization of a prescription drug does not modify the prescription drug tier list. Inclusion of a drug or related item on the prescription drug tier list is not a guarantee of coverage. Coverage is subject to all of the terms of your Subscriber Certificate and this rider. The appeal procedure outlined in your Subscriber Certificate is available if you disagree with Anthem’s Prior Authorization decision.

A *Prescription Drug Program* flyer was issued with your Certificate. For the most current information about drugs requiring Prior Authorization, please call Anthem’s Customer Service for assistance. The toll free telephone number is listed on your identification card. Or, call Anthem at 1-800-874-7122, or visit Anthem’s website www.anthem.com.

**VI. Exclusions**

In addition to the limitations and exclusions stated in Section 8 of your Subscriber Certificate, the following services are not covered.

- Prescriptions taken by or administered to a Member in any Outpatient setting (except as stated in this rider); Prescriptions taken by or administered to a Member who is a patient in a licensed hospital, nursing home, sanitarium or similar institution, or charges for such administration.
- Appetite suppressants, anorectics, or any drug used for the purpose of weight management
- Vaccines, toxoids (substance used to produce immunity such as tetanus toxoids)
- Biologicals, blood or blood plasma, plasma expanders or proteins
- Cosmetic agents or medications used for cosmetic purposes
- Prescriptions that are not approved by the FDA for clinical use
- Nonlegend (over-the-counter) prescriptions, including:
  - prescriptions for which there is an over-the-counter (OTC) therapeutic equivalent,
  - vitamins or other dietary substances that do not require a prescription by law,
  - supplies that can be used for non-medical purposes, such as alcohol or alcohol wipes, and
  - homeopathic products or herbal remedies.
- Replacement prescriptions resulting from loss, theft, or damage
- Compounded Prescription Legend Drugs without ingredients requiring a prescription order
- Therapeutic devices or appliances, support garments and non-medical substances regardless of intended use, including non diabetic needles and syringes. Please see your Subscriber Certificate for more information about coverage for some of these items.
- Prescription refills that exceed the physician’s order or refills dispensed after one year from the physician’s original order.
- Any prescription that is not Medically Necessary, as defined in your Subscriber Certificate.
- Drugs used for the treatment of impotency and sexual dysfunction
- Prescription legend and nonlegend drugs, medications, supplies, devices or any other services to eliminate or reduce dependency on, or addiction to tobacco and tobacco products
- Fertility hormones and fertility drugs.

### VII. Definitions

**Brand Drug** means a prescription that is marketed under its trade name.

**Generic Drug** means a prescription that is chemically and therapeutically equivalent to a Brand name product.

**Maximum Allowed Amount.** For prescription drugs, the Maximum Allowed Amount is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy Benefits Management (PBM).

**Network Pharmacy** means a pharmacy that has a written agreement with the Pharmacy Benefits Management to provide Covered Services to Members. Network Pharmacies accept Anthem’s Maximum Allowed Amount as payment in full for Covered Services.

**Network Specialty Pharmacy** means a pharmacy that has a written agreement with the Pharmacy Benefits Management to provide Covered Services to Members. Covered Services include providing clinical care support, medication management, coordinating the delivery of medication (directly to you or your physician’s office), and assisting Members in obtaining Prior Authorization. Network Specialty Pharmacies accept Anthem’s Maximum Allowed Amount as payment in full for Covered Services.

**Out-of-Network Pharmacy** means a pharmacy that does not have a written agreement with the Pharmacy Benefits Management to provide Covered Services to Members.

**Prescription Legend Drug, Prescription Drug, or Drug** means 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, which contain at least one such medicinal substance, are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Rider. Over the counter drugs that are recommended by the U.S. Preventive Services Task Force (USPSTF) as Preventive Services are considered Prescription Legend Drugs.

**Prior Authorization** means the process of obtaining authorization for services or certain covered drugs that have been approved by the Food and Drug Administration (FDA) for specific medical conditions by reviewing related documentation, verifying benefits and medical necessity to assure the service is a covered service and is medically necessary. These services are reviewed to make sure the patient is getting the appropriate treatment regimens based on medical guidelines to assure the highest quality outcome for the patient and decreasing costs without compromising the quality of care. The approval criteria was developed and endorsed by the Anthem Pharmacy and Therapeutics Committee and is based on information from the FDA and manufacturers, medical literature, actively practicing consultant physicians and appropriate external organizations.

**Specialty Medication** means prescriptions that are prescribed for the treatment of rare conditions and advanced diseases. These drugs are sometimes difficult to obtain at a retail pharmacy, are often administered by injection and may require special handling, such as temperature controlled packaging. Specialty Medications must be furnished by a Specialty Pharmacy.
VIII. About the Pharmacy Benefits Management

Anthem contracts with a Pharmacy Benefits Management to manage the pharmacy Benefits available under this rider. The Pharmacy Benefits Management has a nationwide network of retail pharmacies, specialty pharmacies and mail order pharmacies.

The pharmacy benefits management has established a National Pharmacy & Therapeutics Committee which consists of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining whether a drug should be included in Anthem’s Formulary; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

**Pharmacy services** - Pharmacy services include, but are not limited to: providing clinical pharmacy management services, making recommendations to and updating the prescription drug tier list, managing a network of retail pharmacies and operating the mail order pharmacy services. In consultation with Anthem, the Pharmacy Benefits Management provides services to promote and enforce the appropriate use of pharmacy Benefits, such as review for possible excessive use; recognized and recommended dosage regiments; optimization of medication therapy; drug interactions or drug/pregnancy concerns.

**Specialty Pharmacy services** - Specialty Pharmacy services include, but are not limited to: providing clinical care support, medication management, coordinating the delivery of medication (directly to you or your physician’s office), and assisting Members in obtaining Prior Authorization.

You may review a copy of the most current prescription drug tier list and Specialty Medications on Anthem’s website www.anthem.com. You may also request copies of these materials by calling Anthem’s Customer Service. The toll free telephone number is listed on your identification card. Or, you may call Anthem at 1-800-874-7122. The prescription drug tier list and Specialty Medication list is subject to periodic review and amendment. Inclusion of a drug or related item is not a guarantee of coverage.

**Anthem Blue Cross and Blue Shield**
3000 Goffs Falls Road, Manchester, 03111-0001
Anthem’s toll-free telephone number is on your Identification Card.

Lisa M. Guertin
President and General Manager
New Hampshire
Domestic Partner Rider

This rider amends your Subscriber Certificate. It is part of your Certificate. Except as stated in this rider, all of the other terms of your Certificate apply.

I. Eligibility. Coverage for Domestic Partners is added to Section 13, “Membership Eligibility, Termination of Coverage and Continuation of Coverage” in your Subscriber Certificate. Coverage is subject to the terms and conditions of this rider.

A. Who is Covered Under the Certificate? For the purposes of this health care plan, a Domestic Partner is an individual who:

- Is not the Subscriber’s lawful wife or husband (the Subscriber’s lawful spouse) or lawful civil union partner, and
- Who meets all of the criteria for domestic partnership stated in the domestic partner affidavit used by your Group.

A Domestic Partner is eligible to enroll as a covered Member in this health plan only if the Subscriber and the Domestic Partner meet all of the eligibility requirements stated in the domestic partner affidavit and provided that both the Subscriber and the Domestic Partner complete the domestic partner affidavit process. The domestic partner affidavit is part of the Member’s application. If the terms of the affidavit are not met, a Domestic Partner is not eligible to enroll.

In order to continue membership eligibility, the Domestic Partner and the Subscriber must continue to meet all of the eligibility requirements established by Anthem and the Group, including the requirements set forth in the domestic partner affidavit. Otherwise, the membership of the Domestic Partner ends.

Please contact your Group for a domestic partner affidavit approved for use by Anthem and by the Group.

In addition to the eligibility criteria set forth in this rider, all other eligibility requirements established by Anthem and your Group must be met by the Subscriber, the Domestic Partner and all other eligible dependents. Otherwise, membership and coverage are not available.

B. Dependent children. For the purposes of this rider, the definition of “dependent children” found in your Certificate applies to the children of a covered Domestic Partner. Please see Section 13 in your Certificate, “Membership Eligibility, Termination of Coverage and Continuation of Coverage,” I “Eligibility” for the definition of a dependent child.

II. Termination of Coverage. The following provision is added to Section 13 in your Certificate, “Membership Eligibility, Termination of Coverage and Continuation of Coverage,” II “Termination of Coverage.”

Termination of a Domestic Partnership. Coverage for a Domestic Partner ends on the first day of the month following the date that an individual fails to meet the definition of a Domestic Partner, as defined in section I “Eligibility” (above) and as detailed in the domestic partner affidavit approved by Anthem and your Group. If coverage for a Domestic Partner ends, coverage ends at the same time for any enrolled children of the Domestic Partner, unless a child meets the definition of an eligible child. Please see Section 13 “Membership Eligibility, Termination of Coverage and Continuation of Coverage,” I “Eligibility” in your Certificate for the definition of a dependent child.

When a Member ceases to be eligible as a Domestic Partner or as the covered child of a Domestic Partner, the Subscriber or the partner is required to submit to the Group and to Anthem a statement of termination approved for use by Anthem and by the Group. The Subscriber must also complete an enrollment form indicating the change within 30 days of the change and must submit the form to the Group and to Anthem. Please contact your Group for the statement of termination and enrollment change form. Failure of the Subscriber to file the statement of termination and/or enrollment change form does not prohibit the Group or Anthem from terminating the membership of an individual who no longer meets the eligibility definitions stated in section I “Eligibility” (above) or any other eligibility requirement established by Anthem and the Group. Please see section III, “General Amendments and Information,” C “Continuation of Group Coverage” (below) for information about continuing Group coverage after coverage would otherwise end.
III. General Amendments and Information. This rider does not amend federal or state laws regarding eligibility, termination or continuation of coverage. However, by accepting this rider, you, your Domestic Partner, your Group and Anthem agree to the following general amendments to your Certificate, Section 13 “Membership Eligibility, Termination of Coverage and Continuation of Coverage.”

A. In establishing an effective date of coverage, the date that a Domestic Partner meets the eligibility requirements stated in this rider will be treated the same as a marriage event. Children of Domestic Partners (including newborn and adopted children and Special Enrollees) have the same rights as stated for any other child covered under your Certificate.

B. Once enrolled, all provisions of Section 13 “Membership Eligibility, Termination of Coverage and Continuation of Coverage” apply to Domestic Partners and their eligible children, except as amended by this rider. The term “spouse,” or “child,” as found throughout Section 13 will apply to Domestic Partners and their children.

C. Section 13 “Membership Eligibility, Termination of Coverage and Continuation of Coverage,” III “Continuation of Group Coverage” is amended for Domestic Partners and their children as follows:

Continuation rights, continuation events, rules regarding qualified individuals, continuation periods, premiums and termination rules will apply to covered Domestic Partners and their covered children as for any other Member. Any provision for continuation privileges of a spouse, widow or Medicare eligible individual stated in COBRA law or NH law will apply to a Domestic Partner covered under this rider, whether or not the applicable law specifically includes Domestic Partners. Any provision for divorce or legal separation events described in COBRA law or NH law will apply to a Domestic Partner who no longer meets the eligibility requirements stated in section I “Eligibility” (above), whether or not the applicable law specifically includes Domestic Partners.

Please note: Anthem reserves the right to terminate the Certificate according to the terms set forth in the Subscriber Certificate and in section II “Termination of Coverage” in this rider. The Group may terminate Domestic Partner eligibility by modifying group coverage to exclude this rider. Membership under the Subscriber Certificate and/or under this rider may terminate if the information supplied in an application for coverage, including the portion of enrollment that includes a completed domestic partner affidavit is fraudulent, misleading, deceptive, incomplete or untrue. Domestic Partners and their covered children are not entitled to any continuation or conversion privilege described in Section 13 “Membership Eligibility, Termination of Coverage and Continuation of Coverage” in the Subscriber Certificate or under the terms of this rider if group coverage was obtained solely based on fraudulent, misleading, deceptive, incomplete or untrue information filed with your Group on a domestic partner affidavit.

Anthem Blue Cross and Blue Shield
3000 Goffs Falls Road, Manchester, New Hampshire 03111-0001

Lisa M. Guertin
President and General Manager
New Hampshire

Call Customer Service at:
Matthew Thornton Blue and Matthew Thornton Blue HealthFirst Members call 1-800-870-3057
HMO Blue New England and BlueChoice New England Members call 1-800-8703122
BlueChoice 2-Tier and 3-Tier Members call 1-800-438-9672
Preferred Blue Members call 1-800-852-6592
Lumenos-Preferred Blue Members call 1-888-224-4896
IMPORTANT INFORMATION


Patient Protection and Affordable Care Act Amendment
This amendment is part of your Subscriber Certificate. It changes the terms of your certificate only to the extent stated herein.

Regardless of any provision in your Subscriber Certificate stating otherwise, the following provisions apply to every portion of your certificate, as required by law:

I. Emergency Care. Emergency Care in a licensed hospital emergency room is covered.

Emergency Care means Covered Services you receive due to the sudden onset of a serious condition. A serious condition is a medical, psychological or substance abuse condition that manifests itself by symptoms of such severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect that immediate medical attention is needed to prevent any of the following:

- Serious jeopardy to the person’s health (including the health of a pregnant woman or her unborn child and, with respect to a behavioral health condition, placing the health of the person or others in serious jeopardy),
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part or serious bodily disfigurement.

Examples of conditions or symptoms that may require Emergency Care are suspected heart attack or stroke, a broken bone, uncontrolled bleeding, unconsciousness (including as a result of drug overdose or alcohol poisoning) or you are at serious risk of harming yourself or another person.

Emergency Care includes all of the Covered Services typically provided in a licensed hospital emergency room including, but not limited to ancillary services to evaluate a person’s condition and further medical examination and treatment as required to stabilize the person.

II. Preventive Health Services. In addition to any preventive care that is covered up to 100% of Anthem’s Maximum Allowable Benefit as shown on your Cost Sharing Schedule, the following preventive health services are covered in full as required by law:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force including, but not limited to: screenings for:
   - Breast cancer;
   - Cervical cancer;
   - Colorectal cancer;
   - High Blood Pressure;
   - Type 2 Diabetes Mellitus;
   - Cholesterol;
   - 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.

The list of preventive health services subject to this amendment may change from time to time. Please call Customer Service for a complete list of preventive health services that are covered in full as required by law. Or, you may visit Anthem’s website at www.anthem.com for information.

Preventive health services must be furnished by your PCP or approved in advance by your PCP’s Referral. Otherwise, no Benefits are available.

In general, the term “preventive health services” refers to medical care for adults and children with no current symptoms or prior history of a medical condition associated with the care. Except as stated in this amendment, Covered Services for maternity care or the diagnosis or treatment of an illness, injury or medical condition are covered under other applicable sections of your certificate.

III. Lifetime and Annual Benefit Maximums.

A. Aggregate Lifetime Dollar Maximums and Aggregate Annual Dollar Maximums. Aggregate lifetime and annual dollar maximums are removed from every portion of your certificate. Aggregate lifetime maximums are dollar limits that apply to all Covered Services in a Member’s lifetime. Aggregate annual maximums are dollar limits that apply to all Covered Services per Member, per year.

B. Benefit-Specific Lifetime Dollar Maximums. A Benefit-specific lifetime dollar maximum is a dollar limit that applies to a specific Covered Service or to a limited group of Covered Services per Member’s lifetime. Benefit-specific lifetime dollar maximums are removed from every portion of your certificate except for:

- Early intervention service as allowed by law

Non-dollar annual limits such as visit limits, age limits, frequency limits and inpatient day limits may apply as shown on your Cost Sharing Schedule and as stated in your certificate.

C. Benefit-Specific Annual Dollar Maximums. A Benefit-specific annual dollar maximum is a dollar limit that applies to a specific Covered Service or to a limited group of Covered Services per Member, per year or in multiple years. Benefit-specific annual dollar maximums are removed from every portion of your certificate except for:

- Early intervention services as allowed by law
- Scalp hair prostheses as allowed by law
- Any annual dollar limit for eyewear that may be covered under your health plan

Non-dollar annual limits such as visit limits, age limits, frequency limits and inpatient day limits may apply as shown on your Cost Sharing Schedule and as stated in your certificate.

IV. Dependent Children.

The definition of a dependent child is as follows:

Dependent children. A dependent child is a Subscriber’s child by blood or by law who is under age 26. Dependent children are your natural children, legally adopted children, children for whom you are the legal guardian, stepchildren
and children for whom you are the proposed adoptive parent and who have been placed in your care and custody during the waiting period before the adoption becoming final. Foster children and grandchildren are not eligible for coverage unless they meet the definition of a dependent child stated in this amendment.

Married and unmarried dependent children who meet the above definition are eligible to enroll as dependents under the Subscriber’s certificate. The spouse of a married dependent child is not eligible to enroll unless the spouse also meets the definition of a dependent child stated in this subsection.

A dependent child who meets the above definition is eligible to enroll whether or not the dependent is a resident of New Hampshire.

A dependent child who meets the above definition is eligible to enroll even if the child is provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Public Law 89-97, 42 U.S.C. 1395 et seq.

Membership eligibility ends for a covered dependent child on the earlier of:

- The date upon which an eligibility condition stated in this amendment ceases to be met. Coverage ends on the first day of the month following the date on which eligibility ends. Exception: Incapacitated Dependents remain eligible for membership as stated in the Subscriber’s Certificate until the dependent is no longer incapacitated, or

- The date upon which the Group ceases to provide coverage to the Subscriber.

V. Rescission. Anthem may terminate a Member’s coverage back to the original effective date for fraud or intentional misrepresentation of a material fact on the part of a covered person. The Subscriber and any applicant age 18 or older represent that all statements made in the enrollment forms and those of dependents are true to the best of their knowledge and belief. Any act or practice that constitutes fraud or an intentional misrepresentation of material fact may cause Anthem to terminate a Member’s coverage back to the original effective date, provided that the rescission occurs within two years from the Subscriber’s date of enrollment.

Anthem Blue Cross and Blue Shield
3000 Goffs Falls Road, Manchester, New Hampshire 03111-0001

Lisa M. Guertin
President and General Manager
New Hampshire

Call Customer Service at:
Matthew Thornton Blue and Matthew Thornton Blue HealthFirst Members call 1-800-870-3057
HMO Blue New England, Network Blue New England and Access Blue New England Members call 1-800-870-3122
Notice of Amendment

This is to notify you of the following amendments to your Subscriber Certificate.

Extension of Benefits Due To Total Disability

The portion of your Subscriber Certificate describing your right to an extension of Benefits due to total disability is amended. Please see Section 13, “Membership Eligibility, Termination of Coverage and Continuation of Coverage,” III “Continuation of Coverage” in your certificate. Subsection F “Total Disability Benefits” is removed from Section 13, III and is replaced by the following amendment:

F. Extension of Benefits Due To Total Disability. Certain New Hampshire regulations provide extension rights for Members with continuous Total Disabilities, even if a Member does not elect to continue coverage as otherwise described in Section 13, III. New Hampshire regulations provide for the following:

You are entitled to an extension of the Benefits described in this notice when:

- Your group coverage with Anthem ends, and
- You have a continuous Total Disability on the termination date.

If you are entitled to Benefits for a continuous Total Disability existing on the cancellation date, Benefits for that disability will be allowed for up to 12 months beyond the Group’s date of cancellation.

Your eligibility for an extension of Benefits for a continuous Total Disability ends when:

- The 12-month continuous Total Disability period ends, or
- Your continuous Total Disability ends, or
- You reach the limit of Benefits available to you under your certificate, whichever event occurs first.

A Member has a continuous Total Disability if:

- The Member is totally disabled from engaging in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and
- The Member is not engaged in any employment or occupation for wage or profit.

You (or someone acting for you) must notify Anthem that you qualify for an extension of Benefits due to Total Disability. To do so, please call Customer Service for assistance.
Total Disability extensions are not available for services connected to dental expenses.

Total Disability extensions are available only to Members of fully-insured plans. Members whose plans are fully funded by an employer, trust or other entity should contact the plan’s Group Benefits Administrator for information about coverage for the disability.

10237NH (9/10)

Anthem Blue Cross and Blue Shield
3000 Goffs Falls Road, Manchester, 03111-0001

Lisa M. Guertin
President and General Manager
New Hampshire

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HMO Blue New England, Network Blue New England and Access Blue New England Members call 1-800-8703122
SUMMARY NOTICE OF CONTINUATION COVERAGE RIGHTS

This notice explains the options available to you for continuing or extending your Group coverage after the coverage would otherwise end.

Continuation and Conversion Laws. Certain provisions of law affect your rights to continue coverage when group coverage would otherwise end. Examples of such laws are state statutes and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). In general, federal COBRA law applies if your employer had an average of 20 or more benefit-eligible employees during the year. If you have any questions about continuation of group coverage under New Hampshire laws or federal laws, please contact your Group Benefits Administrator immediately.

New Hampshire law allows you to continue coverage when group coverage would otherwise end.

A. Continuation for Divorce or Legal Separation. If you and your spouse are divorced or legally separated while you are a member of a Group Health Plan, your former spouse is eligible to remain on your policy, as an active dependent until the earliest of the following events occurs:

- Remarriage of the Subscriber;
- Remarriage of the former spouse;
- Death of the Subscriber;
- The 3-year anniversary of the final decree of divorce or legal separation; or
- Such earlier time as provided by the final divorce decree or legal separation

NOTE: If the covered divorced or legally separated spouse is 55 years old or older, the former spouse may continue coverage until the date that he or she becomes eligible for coverage under another group health care plan, enrolls in Medicare, or first becomes eligible for Medicare after the date of the divorce or legal separation, whichever occurs first.

When one of the above events occurs, your Group Benefit Administrator must notify Anthem of your former spouse’s ineligibility. Your former spouse may be eligible under the State of New Hampshire Continuation provisions described in B, below.

If your Group replaces this coverage with another insurance carrier, your former spouse may be eligible to continue as your active dependent under the replacement policy. Please consult with the replacement carrier for complete information.

B. New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End. This section applies if you experience a Continuation Event.

- If your employer has one benefit-eligible employee, please see C (below).
- You are not an eligible employee or dependent if you were not covered under the group plan at the time of the Continuation Event.
- You are not an eligible employee or dependent if you are eligible for other group coverage or you are enrolled in Medicare when a Continuation Event occurs. (If you are entitled to Medicare but not enrolled for Medicare benefits at the time of a Continuation Event, you should contact your local Social Security Office immediately for assistance because continuation ends on the first day that you become eligible for Medicare.

For the purposes of this article, “eligible for Medicare” means that you are entitled to enroll in Medicare:

- on a date outside the Medicare open enrollment period without application of the Medicare penalty for late enrollment, or
• on a date during an open enrollment period,

whichever date occurs first.

Continuation Events. Eligible employees and their eligible dependents can elect to continue group coverage under NH law when one of the following events occurs:

• your employment is terminated for any reason (except gross misconduct),

• your hours of employment are reduced so that you no longer qualify to participate in your employer health care plan,

• coverage is reduced or terminated within one year of the date your employer files for protection under the bankruptcy provisions of Title 11 of the United States Code, or

• the eligible employee dies.

Eligible dependents can elect to continue group coverage when one of the following events occurs:

• a dependent child no longer meets Anthem’s definition of a dependent child, dependent student or incapacitated child,

• you (the ex-employee) and your dependents are on an 18 month continuation period and your continuation ends because you enroll in Medicare or you become eligible for Medicare following a Continuation Event.

Continuation Periods. You and your covered dependents may continue coverage for up to 18 months if:

• your employment is terminated for any reason (except gross misconduct), or

• your hours of employment are reduced so that you no longer qualify to participate in your group’s health care plan, or

• coverage is reduced or terminated within one year of the date your employer files for protection under the bankruptcy provisions of Title 11 of the United States Code.

You may continue coverage for up to 29 months if you are disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of a continuation period. (Medicare begins coverage for the disabled at 29 months.) For ease of administration, you should contact your Group and Anthem as soon as possible after you are notified of your disability status by the Social Security Administration.

Your covered surviving spouse may continue coverage for up to 36 months if coverage would otherwise end because of your death. If your surviving spouse is 55 years old or older, he or she may continue coverage until the date that he or she becomes eligible for coverage under another group health care plan, enrolls in Medicare, or first becomes eligible for Medicare after your death, whichever occurs first.

Your covered spouse may continue coverage for up to 36 months if coverage would otherwise end because your spouse is on an 18 month continuation with you and your continuation ends because you enroll in Medicare or you become eligible for Medicare.

Your covered dependent may continue coverage for up to 36 months if coverage would otherwise end because:

• the child no longer meets Anthem’s definition of a covered dependent child, or
• because of your death, or

• the child is on an 18 month continuation with you and your continuation ends because you enroll in Medicare or you become eligible for Medicare.

Note: If any of the above events occur during an 18 month continuation period, the time spent on the 18 month period counts toward a total of 36 months of continued coverage for your child.

Notifications. Within 30 days of receiving notice from your Group’s Benefit Administrator that you and/or your covered dependent(s) became ineligible for coverage under your group health benefit plan, you and/or your covered dependent(s) will receive a letter from Anthem notifying you and/or your covered dependent(s) of your right to elect to continue coverage.

The letter will contain information about your right to continue coverage, the amount of premium required to continue coverage and the procedure for electing continuation coverage. You will have 45 days from the date of the letter to make your election by notifying the Group Benefit Administrator of your decision to elect coverage. Your Group Benefit Administrator will notify Anthem of your election to continue coverage.

Continuation Premium. The premium for continued coverage will not be more than 102 percent of the premium charged for employees with similar coverage. The initial premium payment must be paid to your employer at the same time as you submit your initial election of coverage. You must pay subsequent premiums and the administrative fee to your employer by the due date, as stated on your invoice. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. You will be notified within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period.

Continuation Ends. Continuation of group coverage ends on the earlier of one of the following events:

• you become eligible for other group coverage (if you enroll in another group health care plan which contains preexisting condition or waiting period limitations, you may continue coverage only until such limitations cease),

• you enroll in Medicare or on the date that you first become eligible for Medicare following a Continuation Event,

• you do not pay the required premium and administrative fee on time, or your employer (or the insurer) terminates all health benefits for all employees.

• the legal time period of your Continuation Event has expired.

C. Options for health coverage after Continuation Ends.

If your group coverage ends for any reason, including the expiration of the legal time period of your Continuation Event, you may convert to an Anthem non-group plan, provided that:

• You have been insured under the group plan for at least 60 days; and

• You are not covered (or eligible for coverage) under another group policy; and

• You apply within 31 days after the termination of the group coverage.
New Hampshire Non-group Conversion – You will be responsible to pay the full premium for the converted non-group policy according to a schedule as invoiced by Anthem.

Individual Insurance Offered by Anthem. Anthem offers individual health insurance to New Hampshire residents. In general, Anthem’s individual policies are offered to residents who are not eligible for other group coverage or Medicare. If you lose group coverage (including loss of coverage when your continuation coverage ends), please contact Anthem for complete information about individual insurance plans.

Also available is Individual Insurance Offered by the New Hampshire High Risk Pool. New Hampshire provides eligibility for an individual policy of insurance offered by the New Hampshire High Risk Pool without additional pre-existing condition exclusions and without first seeking coverage through another individual insurance plan. The New Hampshire High Risk Pool does not require evidence of insurability. Other requirements may apply. For example, NH residency may be required. For more information contact the New Hampshire High Risk Pool directly at (1-877-888-6447) or visit the plan’s website at www.nhhealthplan.org.

D. Termination of the entire group health plan (39-week). If an employer sponsored group health care plan is terminated for all employees for any reason, members who are covered at the time of such termination may elect to continue the benefits of the plan at the same group rate (plus a two percent administrative fee) as follows:

- for up to 39 weeks;  (NOTE: where an individual is already on continuation coverage, coverage shall continue until it would have expired had the plan not been terminated or for 39 weeks, whichever occurs first.),
- until the required premium is not paid on time, or
- until the continuing member becomes eligible for benefits under another group plan (including Medicare), whichever event occurs first.

Exception: If you enroll in another group health benefit plan while you are continuing coverage under this statute and the new plan contains preexisting condition or waiting period exclusions or limitations, you may continue coverage under this statute only until such limitations cease.

(If your Group canceled coverage with Anthem for all employees because the Group contracted for coverage with another carrier, you are always considered to be eligible for coverage under the new plan and you are not eligible to continue coverage.)

Anthem will send you a written notice explaining your right to continue coverage under this statute within 30 days of the date your group coverage terminated. Our notice will include information about the conditions of coverage and the premiums that you must pay in order to continue coverage. The election period is a period of 31 days from the date of Anthem’s notice. To elect the 39-week extension, you must do both of the following with the election period.

- notify Anthem in writing that you elect to continue coverage under this statute, and
- provide the first monthly premium (plus a two percent administrative fee).

Note: Our written notice will be presented to you or mailed to you. If mailed, we will use the most current address on file at our office. Provided that you notify us in writing within this additional period and provided that you submit the required payment with your notification, the effective date of your continuation under this law is the group’s cancellation date. (You are responsible for making payments as billed by Anthem for your extension of group coverage under this law. You are not responsible for paying Anthem for any premiums that were the Group’s responsibility prior to the Group’s cancellation date.)

After we receive your written notice of election (and your premium payment plus a two percent administration fee), Anthem will bill you for subsequent payments.
You must pay the required premium and administrative fee to Anthem by the due date as stated on your invoice. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. Anthem will notify you within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period.

E. Continuation of Group Coverage Due to Military Service (USERRA). 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 your 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 Certificate 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 employee contribution, if any, for continuation of health coverage. If continuation is elected under this provision, the maximum period of health coverage under your Certificate shall be the lesser of:

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

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

F. Extension of Benefits Due To Total Disability. Ordinarily, if your Group coverage ends, no further Benefits are available to continue or extend your group coverage under your Certificate except as stated above in this notice. However, certain New Hampshire regulations provide extension rights for Members with continuous Total Disabilities, even if the Member does not elect to continue coverage as described above. New Hampshire regulations provide for the following:

You are entitled to an extension of the Benefits described in your Certificate when:

- Your group coverage with Anthem ends, and
- You have a continuous Total Disability on the termination date.

If you are entitled to Benefits for a continuous Total Disability existing on the cancellation date, Benefits for that disability will be allowed for up to 12 months beyond the Group’s date of cancellation.

Your eligibility for an extension of Benefits for a continuous Total Disability ends when:

- The 12-month continuous Total Disability period ends, or
- Your continuous Total Disability ends, or
- You reach the limit of Benefits available to you under your Certificate, whichever occurs first.
A Member has a continuous Total Disability if:

- The Member is totally disabled from engaging in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and
- The Member is not engaged in any employment or occupation for wage or profit.

You (or someone acting for you) must notify Anthem that you qualify for Total Disability Benefits, as described in this notice. To do so, please call Customer Service for assistance.

Total Disability extensions are not available for services connected to dental expenses.

Total Disability extensions are available only to Members of fully-insured plans. Members whose plans are fully funded by an employer, trust or other entity should contact the plan’s Group Benefits Administrator for information about coverage for the disability.

G. Strike, Lockout or other Labor Dispute. If your Group pays part or all of the premiums required to maintain coverage under your Certificate and your compensation is suspended or terminated directly or indirectly as the result of a strike, lockout or other labor dispute, you the employee may maintain coverage under your Certificate for up to 6 months from the date your compensation is suspended. You must make premium payments on time directly to your Group during the 6-month period. Your Group must remit your payments to Anthem by the due date, as shown on Anthem’s invoice issued to your Group.

During the 6-month period, your Group coverage cannot be altered or changed except for modifications that can occur upon expiration and renewal of your Group plan and the decreases or increases of the premium rate upon renewal.

Under New Hampshire law, your Group is required to notify you in writing immediately upon suspension or termination of your compensation as the result of a strike, lockout or other labor dispute. Notice must be sent by mail to the address last on record with your Group.

Eligibility for coverage ends when the earliest of the following events occurs:

- You become a full-time employee with another employer, or
- Your premiums are not remitted when due. If you do not pay the premium by the due date, a 30-day grace period will be provided. Your continuation coverage will end if you do not pay the premium by the end of the 30-day grace period. You will be notified within 15 days before your coverage is terminated for failure to pay the premium by the end of the grace period, or
- 6 months after your compensation is suspended or terminated as the result of a strike, lockout or other labor dispute.

After the 6-month period ends, you, the employee may continue coverage under your Certificate for an additional 12 months as if you originally had elected the rights provided under B, “New Hampshire Continuation of Coverage When Group Coverage Would Otherwise End” and subject to the same conditions stated in B. At the end of the additional 12 months, you, the employee shall have the right to convert to an individual policy as described in C, “Options for health coverage after Continuation Ends.”
Discretionary Clause Endorsement

The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Under ERISA, Anthem Health Plans of New Hampshire, Inc. d/b/a Anthem Blue Cross and Blue Shield (Anthem) is hereby designated by the plan sponsor as a claim fiduciary with discretionary authority to determine eligibility for benefits and to interpret and construe the terms and provisions of the policy. As claim fiduciary, Anthem has a duty to administer claims solely in the interest of the participants and beneficiaries of the employee benefit plan and in accordance with the documents and instruments governing the plan. This assignment of discretionary authority does not prohibit a participant or beneficiary from seeking judicial review of Anthem’s benefit eligibility determination after exhausting administrative remedies. The assignment of discretionary authority made under this provision may affect the standard of review that a court will use in reviewing the appropriateness of Anthem’s determination. In order to prevail, a plan participant or beneficiary may be required to prove that Anthem’s determination was arbitrary and capricious or an abuse of discretion.

This designation as a claim fiduciary under ERISA does not apply to determinations that health carriers make as to whether a health care service, supply or drug meets requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.