HealthTrust

Access Blue New England Subscriber Certificate

What You Need to Know about Your Managed Health Care Plan

THIS CERTIFICATE REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT OF 2010, AS AMENDED. ANY REQUIRED CHANGES RESULTING FROM THE RELEASE OF ADDITIONAL GUIDANCE WILL BE INCORPORPORATED INTO THIS SUBSCRIBER CERTIFICATE.

Anthem

Welcome!

Your medical coverage is provided through an arrangement between HealthTrust and Anthem Blue Cross and Blue Shield (Anthem). This means you and your covered family members have access to:

- High quality care where and when you need it. Your plan includes an extensive Provider network to connect you with the best healthcare Providers.
- LiveHealth Online, Anthem's innovative service that lets you access board-certified doctors 24/7 from anywhere you have a computer or phone with a webcam.
- HealthTrust's Slice of Life wellness program, providing resources and rewards for making smart lifestyle choices.
- And much more.

To get the most out of your plan, take a minute to create your own secure online account at *www.healthtrustnh.org*. Click "Secure Login" on the homepage, then "New User." Your secure account will give you access to information and resources not available to the general public, as well as direct links to our vendor partner sites to participate in these and other valuable programs.

How to Get Language Assistance – HealthTrust and Anthem are committed to communicating with you about your Plan, no matter what your language is. Anthem provides a language line interpretation service for use by you and your covered family members. Simply call Anthem Member Services at the telephone number on your identification card and a representative will be able to help you. Translation of written materials about your Benefits can also be asked for by contacting Anthem Member Services. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with your needs.

Please review this Subscriber Certificate, and keep it with your other important papers for future reference. If you have questions, please contact HealthTrust or Anthem during business hours.

To call us:
HealthTrust Enrollee Services: 1-800-527-5001

Anthem Member Services: See the number on your identification card

To write us:
HealthTrust
PO Box 617
Concord, NH 03302-0617

Anthem Blue Cross and Blue Shield
PO Box 660
North Haven, CT 06473-0660

To visit us:
HealthTrust
25 Triangle Park Drive
Concord, NH

To visit our website:
HealthTrust: *www.healthtrustnh.org*

Anthem: *www.anthem.com*

Thank you for the privilege to serve your health plan needs and to help you live your healthiest life.

Scott DeRoche

Scott DeRoche
Executive Director
HealthTrust, Inc.

Maria M. Proulx

Maria M. Proulx
President and General Manager
Anthem Blue Cross and Blue Shield, New Hampshire

TABLE OF CONTENTS

INTRODUCTION

Please see Section 14 for Definitions of specially capitalized words.

This Access Blue New England Subscriber Certificate describes the terms and conditions of Benefits coverage under HealthTrust's Access Blue New England managed health care plan (the "Plan"). Your Group is making the Plan available to You and other eligible Employees as an important employee benefit. This Certificate describes the Benefits available under the Plan as well as Your rights and responsibilities, including procedures You must follow. Benefits are provided and funded by HealthTrust, Inc. ("HealthTrust"), while Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield ("Anthem"), provides certain administrative services, including claims processing and utilization management.

HealthTrust has sole and exclusive discretion in interpreting coverage and Benefits available under the Plan including the terms, conditions, limitations and exclusions set forth in this Certificate, and in making factual determinations related to Benefits. HealthTrust may, from time to time, delegate discretionary authority to other persons or entities providing services in regard to the Plan (for example, Anthem). Examples of such delegation of discretionary authority appear in this Certificate where HealthTrust provides Anthem the right to make the final determination of Benefits for Covered Services. Any change or amendment to the Plan or this Certificate must be made in writing and must be duly adopted by HealthTrust. No person or entity has any authority to make any oral changes or oral amendments to the Plan or this Certificate. HealthTrust further reserves the right to terminate the Plan by giving advance notice of at least 30 days to You and Your Group.

HealthTrust may, in its sole discretion, arrange for various persons or entities (for example, Anthem) to provide administrative services in regard to the Plan, including claims processing and utilization management services. The identity of the service provider and the nature of the services provided may be changed from time to time, at the sole discretion of HealthTrust, and without prior notice to or approval by Groups or Members.

SECTION 1: HOW YOUR PLAN WORKS – GENERAL INFORMATION

Please see Section 14 for Definitions of specially capitalized words.

I. About This Certificate

This is Your Access Blue New England Subscriber Certificate. It describes the relationship among You, Your health care Providers, Your Group and the Plan. You and Your eligible Dependents are entitled to the Benefits described in this Certificate provided that all conditions for eligibility and enrollment described in Section 13 have been met. Certain rights and responsibilities are also described in this Certificate.

Your Cost Sharing Schedule (enclosed with this Certificate) is an important part of Your Certificate. It lists Your cost sharing amounts (Copayments, Deductibles and Coinsurance). Certain Benefit limitations are also shown on Your Cost Sharing Schedule. HealthTrust may issue riders or endorsements that amend this Subscriber Certificate by describing additional Covered Services or limitations. Please read Your Certificate carefully, because it explains the terms of Your coverage.

II. Your Primary Care Provider (PCP)

In this Certificate, Your Primary Care Provider is called Your PCP. Each Member must select a PCP at enrollment time. PCPs include internists, family/general practitioners, Advanced Practice Registered Nurses (APRNs), and pediatricians or any other practice allowed by the Plan.

To select Your PCP, use the Provider directory on the HealthTrust website (*www.healthtrustnh.org*) or log in to Your HealthTrust secure account, click on the Anthem button and use the "Find a Doctor" tool on the Anthem website. You may also contact Anthem Member Services telephone number on Your identification card.

It is recommended that You talk to Your PCP *before* You receive health care services. If You need specialized care, Your PCP may assist in coordinating Your care by working with the hospitals, specialists and suppliers in the Network. For Out-of-Network Services, Your PCP must authorize a Referral *in advance* unless the services are subject to the No Surprises Billing Act. Benefits will be denied if You do not obtain Your PCP's Referral as required unless the services are subject to the No Surprises Billing Act. Please see Section 4 and the Consolidated Appropriations Act, 2021 Notice at the end of this Subscriber Certificate for more information.

III. The Network

Providers who have network agreements directly with the same Local Plan make up a "Designated Network." The affiliated New England Blue Cross and Blue Shield plans share access to their Designated Networks by mutual agreement. For the purposes of this Certificate, all Designated Networks combined are referred to as "the Network." Also for the purposes of this Certificate, each Provider in a Designated Network is a Network Provider.

- **Network Providers in New Hampshire** are Providers, including Primary Care Providers (internists, family/general practitioners, Advanced Practice Registered Nurses (APRNs), and pediatricians) and specialists, hospitals and other health care Providers and facilities that have a network payment agreement directly with Anthem to provide Covered Services to Members. New Hampshire Network Providers are listed in the New Hampshire Provider Directory which is updated periodically. To locate the most up-to-date information about New Hampshire Network Providers, visit *www.healthtrustnh.org*, click on the medical icon on the homepage, then click on the applicable Provider directory button for Your Plan. You may also contact Anthem Member Services at the telephone number on Your identification card. Anthem Member Services can help you determine the Provider's name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.

- **Network Providers Outside New Hampshire** are Providers, including Primary Care Providers (internists, family/general practitioners, Advanced Practice Registered Nurses (APRNs), and pediatricians), and specialists, hospitals and other health care Providers and facilities *outside New Hampshire* that have a written payment agreement directly with one of the affiliated New England Local Plans. Network Providers are listed in each Local Plan's Network Directory which is updated periodically. To locate the most up-to-date

information about Providers located outside of New Hampshire, visit *www.healthtrustnh.org*, click on the medical icon on the homepage, then click on the applicable Provider directory button for Your Plan.

Scroll down to the section that says, "Click on the state link below to access that state's Anthem website and/or Provider directory." You may also contact Anthem Member Services at the telephone number on Your identification card.

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 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. Such subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, or Member Services 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 You, the Member. Contracting arrangements between Network Providers and Anthem or between Network Providers and one of the Local Plans 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. Providers, hospitals, facilities and other Providers who are not Network Providers are Out-of-Network Providers.

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

IV. Group Coverage

You are covered under this Certificate as part of a Group. Eligibility rules are determined by Your Group and HealthTrust. By submitting Your signed Medical Enrollment Application and by authorizing Your Group to make premium payments to HealthTrust on Your behalf, 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 HealthTrust as described in Section 13, II.

V. Services Must be Medically Necessary

Each service that You receive must be Medically Necessary. Otherwise, no Benefits are available. This requirement applies to each Section of this Certificate. The definition of Medically Necessary is stated in Section 14.

Anthem is given the right to review services after they have been furnished in order to confirm that they were Medically Necessary. If the services of a Network Provider are later determined to not be Medically Necessary, the Network Provider is prohibited from billing You for the portion of services that would have been covered if they had been Medically Necessary unless You have otherwise agreed in writing before You receive the services. You are responsible for the full cost of services provided by an Out-of-Network Provider that Anthem determines to be not Medically Necessary.

VI. No Preexisting Condition Exclusions

HealthTrust does not apply or enforce any preexisting condition exclusions with respect to Your coverage under the Plan.

VII. Contact Information for HealthTrust and Anthem

If You have any questions about Your health plan coverage or Benefits available under this Certificate, please call or write to HealthTrust or Anthem at the locations listed below. All correspondence with HealthTrust or Anthem should include Your Group name and number, Your identification number and Your telephone number.

Contact HealthTrust at:
HealthTrust
PO Box 617
Concord, NH 03302-0617
Telephone Number: 603-226-2861 or 1-800-527-5001

Contact Anthem at:
Anthem Blue Cross and Blue Shield
PO Box 660
North Haven, CT 06473-0660
Member Services Telephone Number: See Your identification card

SECTION 2: COST SHARING TERMS

Please see Section 14 for Definitions of other specially capitalized words.

Your Plan may include Copayments, Deductibles, and/or Coinsurance, which are charges that You must pay when receiving certain Covered Services. Your Plan also has an Out-of-Pocket Limit, which limits the overall cost sharing You must pay during a Plan Year. Please see Your Cost Sharing Schedule for specific cost sharing amounts.

Depending on the cost sharing 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 amount can vary by the type of Covered Service You receive. For example, You may have to pay a $20 Copayment for an office visit, but a $100 Copayment when You visit a hospital emergency room. See Your Cost Sharing Schedule for details on Copayment amounts and requirements.

Please note: Copayments do not count toward any Deductible or Coinsurance requirements or maximums. In addition to a Copayment, a Deductible and/or Coinsurance may apply. For example, Your Plan may include a Deductible and Coinsurance for the Provider and ancillary services furnished during Your visit to an emergency room or an Urgent Care Facility. 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."

II. Deductible

A Deductible is a fixed dollar amount that You pay for each Member's Covered Services each Plan Year before Benefits are available under this Plan.

A Standard Deductible only applies if shown on Your Cost Sharing Schedule, and may only apply to certain Covered Services. See Your Cost Sharing Schedule for details.

A separate Deductible may apply to Your Durable Medical Equipment, Medical Supplies and Prosthetics coverage. Please refer to Section 7, IV, E. This Deductible, if applicable, is shown on Your Cost Sharing Schedule. This is a separate Deductible requirement that does not count toward meeting Your Standard Deductible amount.

III. Coinsurance

After any applicable Deductible is met, Your Plan pays a percentage of the cost of certain Covered Services. You also may be required to pay a percentage. The percentage that You pay is called "Coinsurance."

Standard Coinsurance only applies to Covered Services if shown on Your Cost Sharing Schedule. See Your Cost Sharing Schedule for details.

A separate Coinsurance may apply to Your Durable Medical Equipment, Medical Supplies and Prosthetics coverage. Please refer to Section 7, IV, E. This Coinsurance amount, if applicable, is shown on Your Cost Sharing Schedule. This is a separate Coinsurance requirement that does 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 may apply. Please refer to 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 Plan Year. When a family Deductible is met, no further Deductible is required for the family for the remainder of the Plan 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 Plan Year. When a family Coinsurance Maximum is met, no further Coinsurance is required for the family for the remainder of the Plan 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 Maximum may apply to Your Durable Medical Equipment, Medical Supplies and Prosthetics coverage. Please refer to Section 7, IV, E. These amounts, if applicable, are shown on Your Cost Sharing Schedule. These are separate requirements that do not count toward meeting any other 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. **Amounts That Exceed the Maximum Allowed Amount.** Benefits under this Plan are limited to the Maximum Allowed Amount. "Maximum Allowed Amount" means the dollar amount available for a specific Covered Service. This is determined as stated in Section 9, I.

Deductible amounts are limited to the Maximum Allowed Amount. Coinsurance is a percentage of the Maximum Allowed Amount. Amounts that exceed the Maximum Allowed Amount do not count toward meeting any cost sharing requirements or Out-of-Pocket Limit, except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" at the end of this Subscriber Certificate.

Please note: Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount.

B. **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 under this Certificate. This applies even if a PCP or other Provider prescribes orders or furnishes the service. Amounts You pay for noncovered or excluded services do not count toward meeting any cost sharing requirements or Out-of-Pocket Limit.

VI. Out-of-Pocket Limit

The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments You pay during a Plan Year. The Out-of-Pocket Limit does not include Your premium, amounts over the Maximum Allowed Amount, or charges for noncovered or excluded services. Your Out-of-Pocket Limit is shown on Your Cost Sharing Schedule.

When a Member's Out-of-Pocket Limit is met, no further Deductibles, Coinsurance, or Copayments are required for that Member for the remainder of the Plan Year. When a family Out-of-Pocket Limit is met, no further Deductibles, Coinsurance, or Copayments are required for the family for the remainder of the Plan Year. No one Member may contribute more than his or her individual Out-of-Pocket Limit toward meeting the family Out-of-Pocket Limit.

SECTION 3: OPEN ACCESS TO NETWORK SERVICES

Please see Section 14 for Definitions of specially capitalized words.

I. Open Access to Network Services

You have the freedom to seek Covered Services from any Network Provider in any Designated Network. You do not need a Referral from Your PCP in order to access the Covered Services described in this Certificate, provided that Your care is furnished by a Network Provider. Please see Section 1, III, "The Network" for more information about the Designated Networks shared by affiliated Blue Cross and Blue Shield plans.

Although You do not need a PCP Referral to access Network Services in any of the Designated Networks, You are encouraged to contact Your PCP when You need health care services. By furnishing Your primary care, Your PCP will become familiar with Your medical history and can better assist in coordinating Your care when necessary. As explained in article III below, "Approval (Precertification) for Specialized Care in the Network," Your PCP or other Network Provider may be required to contact Anthem or the Local Plan for Precertification before You receive certain Network Services.

Also, as explained in Section 4, "Access to Out-of-Network Services," You must obtain Your PCP's Referral, and also may need Precertification from Anthem or from the Local Plan, before You receive Out-of-Network Services, unless the services are subject to the No Surprises Billing Act.

II. Selecting a PCP or Other Network Provider

A. **Each Member Must Select a PCP in One of the Designated Networks.** Even if You choose to seek Network Services from a Provider who is not Your PCP, You must select a PCP in one of the Designated Networks. 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. Family members may select PCPs in different Designated Networks. Please indicate each family Member's PCP on Your Medical Enrollment Application.
PCPs and other Network Providers are listed in each Local Plan's Network Directory and are updated periodically. For the most up-to-date information about **New Hampshire** Network Providers, please visit *www.healthtrustnh.org*, click on the medical icon on the homepage, then click on the applicable Provider directory button for Your Plan. Or, You may contact Anthem Member Services at the telephone number on Your identification card.

For the most up-to-date information about Network Providers located **outside New Hampshire**, visit *www.healthtrustnh.org*, click on the medical icon on the homepage, then click on the applicable Provider directory button for Your Plan. Scroll down to the section that says, "Click on the state link below to access that state's Anthem website and/or Provider directory." You may also contact Anthem Member Services at the telephone number on Your identification card.

B. **PCP Selection for Newborns.** You should choose Your newborn's PCP before the baby's due date. As soon as possible after Your baby is born, please send a completed Medical Enrollment Application that includes Your newborn's information and PCP selection to Your Group Benefits Administrator. For information on how to enroll Your newborn, please refer to Section 13, II.

C. **Changing a PCP.** If You want to change Your PCP, contact Anthem Member Services or write to Anthem. The change will become effective on the day You call or the day Anthem receives Your written request, unless You request an effective date that comes after the date of Your call or written request. Anthem will honor Your request for a later effective date. You can change Your PCP for any reason Anthem may inquire about Your reason for changing a PCP because Your information helps Anthem to maintain the quality of the Network.

III. Approval (Precertification) for Specialized Care in the Network

Anthem or the Local Plan must approve certain Covered Services *before* You receive them. This approval is called "Precertification" and is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate, including but not limited to Copayment, Deductible, and Coinsurance requirements, and the limitations, exclusions, network restrictions, other party liability rules and eligibility/enrollment rules stated in this Certificate.

Most often, Network Providers, including PCPs, will refer Members to other Network Providers for specialized care. Your Network Provider will obtain any required Precertification from Anthem or from the Local Plan for Network Services. Please see Section 4, "Access to Out-of-Network Services" for important Referral and Precertification rules that apply when You seek Out-of-Network Services.

SECTION 4: ACCESS TO OUT-OF-NETWORK SERVICES

Please see Section 14 for Definitions of specially capitalized words.

I. Referrals and Approval (Precertification) For 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. Certain services such as Inpatient admissions also require approval *in advance* by Anthem or the Local Plan's Precertification.** Your PCP is responsible for providing a Referral and for contacting Anthem or the Local Plan for Precertification. No Benefits will be available if You do not obtain Your PCP's Referral *before* You receive Out-of-Network Services, unless the services are subject to the No Surprises Billing Act.

If Anthem or the Local Plan 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 Urgent and Emergency Care as described in Section 6, 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 or the Local Plan for any required Precertification of the Out-of-Network Services. No Benefits will be Precertified or available for elective Inpatient 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. Generally, no Benefits are available for routine medical exams, immunizations, routine gynecological exams, diagnostic tests related to routine care, other preventive care or any other Outpatient 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 but not limited to, Copayment, Deductible, and Coinsurance requirements and the limitations, exclusions, network restrictions, other party liability rules and eligibility/enrollment rules stated in this Certificate.

II. Benefits are Not Available for Some Out-of-Network Services

The following Covered Services must be furnished by a Network Provider. Out-of-Network Services are not covered, even if You obtain a Referral from Your PCP or other Network Provider:

- **Certain Dental Services.** Please see Section 7, VI, A, "Dental Services." Certain dental services are covered only when furnished by a Network Provider. Otherwise, no Benefits are available.

- **Chiropractic Care.** Please see Section 7, III, C, "Chiropractic Care." Covered chiropractic services must be furnished by a Network Chiropractor, unless otherwise stated in an amendment to this Certificate. No Benefits are available for Out-of-Network Chiropractic Care.

- **Durable Medical Equipment, Medical Supplies and Prosthetics.** Please see Section 7, IV, E, "Durable Medical Equipment, Medical Supplies, and Prosthetics." Covered Services must be ordered *in advance* by Your Network Provider and furnished by a Network Provider. Out-of-Network Benefits are not available.

- **Maternity Care – Midwife Services.** Benefits are available for *routine* maternity care furnished by a Network New Hampshire Certified Midwife (NHCM) who is certified under New Hampshire law. Please see Section 7, II, B, 5, "Maternity care." Out-of-Network Benefits are not available. Services furnished outside New Hampshire are covered only if all of the terms of Section 7, II, B, 5 are met, including NHCM certification under New Hampshire law.

Riders, endorsements or amendments to this Certificate may describe other services that are not covered when furnished by an Out-of-Network Provider.

SECTION 5: ABOUT MANAGED CARE

Please see Section 14 for Definitions of specially capitalized words.

Access Blue is a Managed Health Care Plan. This means that when You receive certain Covered Services, Anthem (or a designated administrator) or the Local Plan works with You and Your health care Providers to determine if You are receiving Medically Necessary services.

A Member's right to Benefits under the Plan is subject to certain clinical policies and administrative procedures. Clinical policies are used by Anthem to determine Benefits and include such things as Anthem's medical policies and utilization review criteria. You may obtain information about these policies by contacting Anthem. Administrative procedures include such things as Precertification, concurrent review and case management. A description of these procedures is provided in this Section and elsewhere in this Certificate. Your failure to follow required administrative procedures will result in a reduction or denial of Benefits.

None of Anthem's employees, or the Providers that Anthem contracts with to make medical management decisions, are paid or provided incentives to deny or withhold Benefits for services that are Medically Necessary and are otherwise covered. In addition, Anthem requires members of its clinical staff to sign an annual statement. This statement verifies that they are not receiving payments that would either encourage or reward them for denying Benefits for services that are Medically Necessary and are otherwise covered.

Your Plan requires that Covered Services be Medically Necessary for Benefits to be provided. To determine Medical Necessity, Your Plan includes the processes of pre-service, concurrent and retrospective reviews to determine when services should be covered by the Plan. The purpose of these processes is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

"Precertification" is the process used by Anthem to review services proposed by Your Provider to determine if the service meets the definition of Medical Necessity. Please see Section 3, III and Section 4, I, as well as article III, A of this Section and Section 14 for more information and definitions of Precertification and Medical Necessity. 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 but not limited to Copayment, Deductible, and Coinsurance requirements, and the limitations, exclusions, network restrictions, other party liability rules and eligibility/enrollment 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 of this Certificate. Knowing and following Plan rules is the best way for You to enjoy all of the advantages of this coverage. For example, Section 3 explains that You need to select a PCP then contact Your PCP or a Network Provider *before* You receive certain health care services. **Please remember that *You* are responsible for obtaining Your PCP's Referral *before* You receive Out-of-Network Services. Please see Section 4 for more information**.

You can help Anthem maintain the quality of its Network by letting Anthem know if You have a concern about the quality of care offered to You by a Network Provider (such as waiting times, Provider behavior or demeanor, adequacy of facilities or other similar concerns). You should discuss Your concerns directly with the Provider, but Anthem also would appreciate knowing about Your experience. Your suggestions about improving the Network are important to Anthem. Please contact Anthem Member Services at the number on Your identification card with Your suggestions.

You can appeal any decision Anthem makes about Your coverage. Please see Section 11 for information about how to use the appeal procedure.

II. The Role of Network Providers

Your Network Providers work together to make sure that You have access to the health care services that You need. Your Network Provider is responsible for overseeing and coordinating Your health care services. Most often, Your Network Provider will provide Your routine or urgent care directly. If Your Network Provider determines that You require specialized care that falls outside his or her clinical expertise or services offered, Your Network Provider will refer You to another Provider. With few exceptions, You will be referred to a Provider in the Network.

Network Providers are required to obtain Precertification in order for You to receive Benefits for certain services. Precertification criteria will be based on multiple sources including medical policy and clinical guidelines. Anthem may determine that a service that was initially prescribed or requested is not Medically Necessary if You have not previously tried alternative treatments which are more cost-effective.

Your Network Provider will contact Anthem or the Local Plan as appropriate for any required Precertification for Your Network Services. For example, if Your Network Provider admits You to a hospital for Inpatient care, Your Network Provider will let Anthem or the Local Plan know about the Precertification and will provide Anthem or the Local Plan with any clinical information that may be required to review the Precertification. Your PCP will also contact Anthem or the appropriate Local Plan to provide the clinical information required for a Referral to an Out-of-Network Provider.

III. The Role of Anthem and the Local Plan

As the administrator of Benefits under this Plan, Anthem's Medical Director and Medical Management Division (and the Medical Directors and medical management divisions of Local Plans) play an important role in the management of Your Benefits. Some examples are:

A. **Referral and Precertification Review.** Network Providers must obtain Precertification from Anthem or the Local Plan's Medical Management Division before You receive Inpatient care and before You receive certain Outpatient services. Emergency admissions must be reported to Anthem as soon as possible so that Anthem can conduct a Precertification review. Please see Section 6, IV for more information. If You have any questions regarding managed care guidelines, or to determine which services require Precertification, please call the number on Your identification card. "Precertification" refers to the process used by Anthem and the Local Plans to review Your health care services to determine if the service is Medically Necessary. Precertification does not guarantee coverage for or the payment of the service or procedure reviewed.

Whenever Anthem or the Local Plan reviews a Network Provider's Referral or any Precertification request, the appropriate Medical Director may discuss the services with Your 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 or from a 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 coverage decision made.

B. **Prior Approval.** At Your Provider's request, Anthem will review proposed services to determine if the service is a Covered Service. For example, if Your Provider proposes a surgery that may be considered cosmetic or dental (and therefore not covered), he or she must submit clinical information for review *before* You receive the service.

C. **Determinations about Medical Necessity.** Anthem is given the right to make determinations about whether or not a service is Medically Necessary. Please see Section 14 for a definition of Medical Necessity.

Your Plan includes the process of utilization review to decide when services are Medically Necessary. Utilization review aids the determination of Medical Necessity by reviewing the use of treatments and, when proper, the level of care including the setting and/or place of service where they are performed. A service must be Medically Necessary to be a Covered Service.

When level of care, setting or place of service is reviewed, services that can be safely provided to You in a lower level of care or lower cost setting/place of care will not be Medically Necessary if they are provided in a higher level of care, or higher cost setting/place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. Examples include, but are not limited to:

- A service may be denied on an Inpatient basis at a hospital but may be approved if provided on an Outpatient basis at a hospital.

- A service may be denied on an Outpatient basis at a hospital but may be approved at a freestanding imaging center, infusion center, ambulatory surgical center, or in a Provider's office.

- A service may be denied at a Skilled Nursing Facility but may be approved in a home setting.

Utilization review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost-effective is available and appropriate. "Clinically equivalent" means a treatment that for most Members will give similar results for a disease or condition.

D. **Determinations about Experimental or Investigational Services.** Anthem is given the right to make determinations about whether or not a service is Experimental or Investigational. Please see Section 8, II for more information about "Experimental or Investigational Services."

E. **Review of New Technologies.** Anthem is given the right to make final determinations about coverage for new technologies. Medical technology is constantly changing and Anthem reserves the right to review and update Medical Policy periodically regarding coverage for new technologies. Anthem evaluates new medical technologies to define medical efficacy 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.

F. **Individual Case Management.** Anthem maintains case management programs that tailor services to the individual needs of Members and seek to improve the health of Members. Case management is Anthem's process of evaluating and arranging for Medically Necessary treatment for Members identified as being eligible for individual case management. Participation in case management programs is voluntary.

Anthem's case managers are registered nurses and other qualified health professionals who 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 is given the right to provide Benefits for care that is Medically Necessary but not listed as a Covered Service in this Certificate. Anthem also is given the right to extend Benefits for Covered Services beyond the Benefit maximums stated in this Certificate. Decisions regarding case management are made on a case-by-case basis. By providing services through case management, the Plan makes exception 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.

Anthem is given 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.

IV. Important Notes About this Section

Benefits are not guaranteed by Your PCP's Referral, Provider's orders, Anthem's Precertification or Prior Approval. Benefits are subject to all of the terms and conditions of the Certificate in effect on the date You receive services.

Anthem's decisions about Referrals, Precertification, Prior Approval requests, Medical Necessity, Experimental or Investigational services and new technologies are not arbitrary. Anthem's Medical Director or Medical Services Division takes into consideration the recommendations of the Member's Provider and clinical information when making a decision about a Member's Benefit eligibility. When appropriate to review a proposed service, Anthem's Medical Director or Medical Services 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 which review the medical effectiveness of health care services and technology.

SECTION 6: URGENT AND EMERGENCY CARE

Please see Section 14 for Definitions of specially capitalized words.

I. Urgent Care

Whenever possible, contact Your PCP or Network Provider for direction *before* You receive Urgent Care. Urgent Care means Covered Services You receive due to a medical or mental health condition or symptomatic illness that if not treated within 48 hours presents a risk of serious harm. 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 may have lower out-of-pocket expenses if it is possible and safe for You to seek care at a Walk-In Center or an Urgent Care Facility as an alternative to a hospital emergency room visit. Please see Your Cost Sharing Schedule to compare the Walk-In Center Copayment and Urgent Care Facility Copayment to the Emergency Room Copayment.

II. Emergency Care

It may not always be possible or safe to delay treatment long enough to consult with Your PCP or Network Provider before You seek care. In a severe emergency, go to the nearest emergency facility immediately for Emergency Care. Call 911 for assistance if necessary.

Emergency Care provided 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 or behavioral health 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
- Serious impairment to bodily functions
- 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.

Medically Necessary services will be covered whether You get care from a Network Provider or Out-of-Network Provider. Emergency Care You get from an Out-of-Network Provider will be covered as a Network Service, and will not require Precertification.

The Out-of-Network Provider can only charge You any applicable Deductible, Coinsurance, and/or Copayment and cannot bill You for the difference between the Maximum Allowed Amount and its billed charges until Your condition is stable as described in the "Consolidated Appropriations Act of 2021 Notice" at the end of this Subscriber Certificate. Your cost shares will be based on the Maximum Allowed Amount and will be applied to Your In-Network Deductible and In-Network Out-of-Pocket Limit.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined using the median Plan In-Network contract rate Anthem pays In-Network Providers for the geographic area where the service is provided.

III. Emergency Room Visits for Emergency Care

Benefits are available for Emergency Care in any licensed hospital emergency room, provided that Your condition meets the definition of Emergency Care as stated in article II of this Section.

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 applicable Emergency Room Copayment is waived if You are admitted to the hospital as a bed patient directly from the emergency room.

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 Your Cost Sharing Schedule to determine Your Deductible and/or Coinsurance for emergency room services such as, but not limited to: the Provider's fee, surgery, diagnostic tests, medical supplies and drugs.

Please note: You may have lower out-of-pocket expenses if it is possible and safe for You to seek care at a Walk-In Center or an Urgent Care Facility as an alternative to a hospital emergency room visit. Please see Your Cost Sharing Schedule to compare the Walk-In Center Copayment and Urgent Care Facility Copayment to the Emergency Room Copayment.

IV. Inpatient Admissions to a Hospital for Emergency Care

Your share of the cost for Inpatient Services is shown on Your Cost Sharing Schedule.

Medical/Surgical and Behavioral Health Admissions for Emergency Care. Benefits are available for an Inpatient admission for medical/surgical and Behavioral Health Emergency Care provided that Your condition meets the definition of Emergency Care as stated in article II of this Section. Treatment You get after Your condition has stabilized is not Emergency Care. Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the end of this Subscriber Certificate for more details on how this will impact Your Benefits.

You (or someone acting for You) must notify Anthem of the admission as soon as possible. Anthem determines whether or not Emergency Care conditions are met by reviewing Your admission records. Call the number on Your identification card to notify Anthem of Your emergency admission.

For maternity admissions, You do not need to contact Anthem for Precertification unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48 hours (or 96 hours) require Precertification.

No Benefits will be available if Your admission was not Medically Necessary. You are responsible for the full cost of the care that is not Medically Necessary.

V. Limitations

In addition to the limitations and exclusions listed in Section 7, VI and Section 8, the following limitations apply to Emergency Care and Urgent 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 Benefits for medical/surgical conditions, Your follow-up care must be provided by a Network Provider and/or authorized in advance by any required Referral or Precertification. Otherwise, no Benefits are available for the follow-up care.

B. When determining whether or not Your services meet the definition of Emergency Care, Anthem will consider not only the outcome of Your emergency room 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 or elective care. Routine care includes, but is not limited to, routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, medication checks, immunizations or other preventive care. Elective care is care that can be delayed until You can contact Your PCP or Network Provider for direction in advance. Examples of elective care include, but are not limited to, scheduled Inpatient admissions or scheduled Outpatient care. Emergency Care and Urgent Care do not include any service related to or resulting from routine or elective care.

D. If You are admitted as a bed patient to an Out-of-Network Hospital for Emergency Care, Benefits are provided only until Anthem and Your PCP or Network Provider determine that Your condition permits Your transfer to a Network Hospital. Any transfer directed by Anthem will be covered.

E. 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.

SECTION 7: COVERED SERVICES

Please see Section 14 for Definitions of specially capitalized words.

This Section describes Covered Services for which Benefits are provided under the Plan. All Covered Services must be furnished by a Provider according to the terms and conditions of the Plan. Preventive Care services are listed in article II, A of this Section. 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.

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 limitations and exclusions described in Section 8 and elsewhere in this Certificate and any amendments to this Certificate.

- To receive maximum Benefits, You must follow the terms of the Certificate, including, when applicable, receipt of care from a Network Provider and obtaining any required Referral or Precertification.

- Benefits for Covered Services are based on the Maximum Allowed Amount for such services. Deductible amounts are limited to the Maximum Allowed Amount. Coinsurance is a percentage of the Maximum Allowed Amount. No Benefits are available for amounts that exceed the Maximum Allowed Amount.

- Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Certificate.

- The Plan's payment for Covered Services will be limited by any applicable Copayment, Coinsurance, Deductible, or annual or lifetime payment limit indicated in this Certificate and on Your Cost Sharing Schedule.

- 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's determinations about Referrals, Precertification, Medical Necessity, Experimental or Investigational Services and new technology are based on the terms of this Certificate, including but not limited to 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 Benefit Determinations regarding Medical Necessity. Please see Section 11 for more information.

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 limited exceptions, Benefits are available only when a Network Provider provides Covered Services.

- Unless subject to the No Surprise Billing Act, Out-of-Network care must be approved by Your PCP and by Anthem or by the appropriate Local Plan in advance based on the terms of this Certificate. If Anthem or the Local Plan 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 are covered. Custodial Care is not covered. Please see Section 8, II, for a definition of Custodial Care.

- **Statement of Rights Under The Newborns' and Mothers' Health Protection Act.**
  Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Provider (e.g., Your Provider, midwife, or physician assistant), after consulting with the mother, discharges the mother or her newborn earlier.

  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.

  In addition, a plan or issuer may not, under federal law, require that a Provider or other health care Provider obtain authorization from the plan or issuer for prescribing a length of stay up to 48 hours (or 96 hours). Therefore, for maternity admissions under this Plan, Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48 hours (or 96 hours) require Precertification.

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 are covered. 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, II for a definition of Custodial Care.

C. **Inpatient Provider and Professional Services.** Provider visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests are covered. Benefits for Inpatient medical care are limited to daily care furnished by the attending Provider, unless another Provider's services are Medically Necessary, as determined by Your Network Provider and Anthem or the appropriate Local Plan. 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, II for a definition of Custodial Care.

Please see article V, "Behavioral Health Care," and article 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. Preventive care includes screenings and other services for adults and children. All recommended preventive care services will be covered as required by the Affordable Care Act (ACA) and other applicable law with no Deductible, Copayments or Coinsurance when You use a Network Provider. These required Covered Services are listed in 1 through 8 below and may change from time to time.

Additional preventive care Covered Services are listed in 9 through 12 below and are subject to the cost sharing requirements, if any, shown on Your Cost Sharing Schedule.

Certain Covered Services for Members who have current symptoms or a diagnosed medical condition may be covered under other applicable Sections of this Certificate if the symptoms or medical conditions do not fall within the Covered Services described in this preventive care Benefit. Additionally, the cost of treatment that results from, but is not part of a preventive care procedure, may be subject to cost sharing as long as the treatment itself is not identified as a preventive care service.

Covered Services fall under the following broad groups:

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

    - Breast cancer, including mammograms and Tomosynthesis (3-D mammograms); diagnostic breast exam and supplemental breast exams will be provided
    - Cervical cancer screening, including pap smears
    - Colorectal cancer, including preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. It also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e., flexible sigmoidoscopy and related prep kit, CT colonography), fecal occult blood test, and barium enema.
    - Lead screening
    - Routine physical exams for babies, children and adults, including an annual gynecological exam
    - High blood pressure
    - Type 2 Diabetes Mellitus
    - Cholesterol
    - Child and adult obesity

2. Immunizations for babies, 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 listed in the guidelines supported by the Health Resources and Services Administration including lead screening.

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

    - Women's contraceptive counseling including Outpatient/office contraceptive services 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.
    - Injectable contraceptives and patches, and contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants
    - Women's sterilization procedures and counseling
    - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy
    - Gestational diabetes screening
    - Annual gynecological exams
    - Obesity prevention in midlife women counseling

5. Genetic counseling.

6. Office visits for routine prenatal care.

7. Nutrition counseling, including but not limited to nutrition counseling for treatment of eating disorders, by a nutrition counselor practicing independently or as part of a Provider practice or Outpatient hospital clinic. Other nutrition counseling Benefits are available when furnished by a Network Home Health Agency. Please see article IV, "Home Health Care Services" for more

information.

Benefits are available for weight management counseling provided during covered nutrition counseling visits or as part of a covered diabetes management program (see 13 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 article 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 Provider 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.

8. Preventive care counseling services for smoking cessation and tobacco cessation for adults and adolescents as recommended by the United States Preventive Services Task Force.

9. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a provider including:

    a. Aspirin
    b. Folic acid supplement
    c. Bowel preparations
    d. FDA-approved preexposure prophylaxis (PrEP), related services and monitoring including follow-up HIV testing and additional testing to monitor the effects of the PrEP medications.

The following preventive care services are subject to the cost sharing requirements, if any, specified on Your Cost Sharing Schedule:

10. Routine hearing exams for Members with no current symptoms or prior history of a hearing illness, injury, or the need for hearing aids for hearing correction. Benefits may be limited as shown on Your Cost Sharing Schedule. Please see article VI, B, "Hearing Services" for information about services for ear disease or injury and the prescribing, fitting and dispensing of hearing aids for hearing correction.

11. Travel and rabies immunizations.

12. Routine vision exams to determine the need for vision correction. The exam must be furnished by an optometrist or ophthalmologist. Otherwise, no Benefits are available. Benefits may be limited, as shown on Your Cost Sharing Schedule. Please see article VI, H, "Vision Services" for information about services for eye disease or injury.

13. Diabetes Management Programs. Covered Services must be ordered by a Provider and furnished by a Diabetes Education Provider. 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 for Members whose external insulin pump has been approved by Anthem. The Diabetes Education Provider must be pump-certified. Please see article IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about coverage for external insulin pumps.

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

- No Benefits are available for services furnished by a Provider who is not a Diabetes Education Provider.

- Insulin, diabetic medications, glucose monitors external insulin pumps and diabetic supplies are not covered under this article. Please see article IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about diabetic supplies. Please contact HealthTrust for information about coverage for insulin, diabetic medication and diabetic supplies.

Benefits are available for weight management counseling provided as part of a covered diabetes management program or during covered nutrition counseling visits (see 7 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 article 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 Provider 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 Provider's Office, Walk-In Center or Retail Health Clinic, through a Virtual Visit, at Home, or Furnished by an Independent Ambulatory Surgical Center, an Independent Infusion Therapy Provider, an Independent Laboratory Provider or an Independent Radiology Provider.

In addition to preventive care services commonly provided in a Provider's office or an Outpatient facility (see article II, A of this Section), the following services are covered:

1. Medical exams, consultations, office 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, CTA, MRA, MRI, PET, SPECT, chemotherapy, infusion therapy.

4. Medical supplies and drugs administered in an office. Benefits are available for covered prescription medications, injectable drugs, radioactive materials, dressings and casts for the prevention of disease, illness or injury or for therapeutic purposes.

   Hormones, insulin and prescription drugs purchased at a Provider's office for use outside the office are not covered under this Certificate. Durable Medical Equipment, Medical Supplies and Prosthetics purchased for use outside a Provider's office are covered under article IV, E of this Section.

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.

   Please 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) who specializes in obstetrics or gynecology, or a Network New Hampshire Certified Midwife (NHCM).

Benefits are available for routine maternity care furnished by a Network 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 during pregnancy are covered only when Medically Necessary.

Out-of-Network Services are not covered unless the services are authorized *in advance* by Your PCP's Referral. Certain services such as Inpatient admissions may also require Precertification by Anthem or the Local Plan.

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 or the appropriate Local Plan must also approve Out-of-Network care *before* the mother leaves the Service Area.

Please see Section 4, "Access to Out-of-Network Services," for important limitations on access to Out-of-Network Services.

C. Outpatient Facility Care in the Outpatient Department of a Hospital, or a Short Term General Hospital's Ambulatory Surgical Center, Hemodialysis Center or a Birthing Center. In addition to preventive care services commonly provided in an Outpatient facility (see article II, A of this Section), Benefits are available for Medically Necessary facility and professional services.

Coverage includes the following:

- Medical exams and consultations by a Provider
- Operating room for surgery or delivery of a baby
- Provider and professional services including surgery, anesthesia, delivery of a baby or management of therapy
- Hemodialysis, chemotherapy, radiation therapy, infusion therapy
- CT Scan, CTA, MRA, MRI, PET, SPECT
- Medical supplies, drugs, other ancillaries, facility charges, including but not limited to facility charges for observation (a period of up to 24 hours during which Your condition is monitored to determine if Inpatient care is Medically Necessary)
- Laboratory and x-ray tests, including ultrasounds

D. Emergency Room Visits for Emergency Care. Benefits are shown on Your Cost Sharing Schedule. Please see Section 6 for important guidelines about Emergency Care.

E. Ambulance Services (Air, Ground and Water). Benefits are available for Medically Necessary ambulance transport services when:

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

- And one or more of the following criteria are met:

    - For ground ambulance, You are taken:

        i. From Your home, the scene of an accident or medical emergency to a hospital;
        ii. Between hospitals, including when Anthem requires You to move from an Out-of-Network hospital to a Network hospital; or

iii. Between a hospital and a Skilled Nursing Facility or other approved facility.

- For air or water ambulance, You are taken:

  i. From the scene of an accident or medical emergency to a hospital;
  ii. Between hospitals, including when Anthem requires You to move from an Out-of-Network hospital to a Network hospital; or
  iii. Between a hospital and an approved facility.

Ambulance services are subject to Medical Necessity reviews by Anthem. Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-emergency ambulance services are subject to Medical Necessity reviews by Anthem. When using an air ambulance for non-emergency transportation, Anthem reserves the right to select the air ambulance Provider. Out-of-Network Providers may bill You for any charges that exceed the Plan's Maximum Allowed Amount. If You do not use the air ambulance Provider Anthem selects, except in an emergency, no Benefits will be available.

You must be taken to the nearest facility that can give care for Your condition. In certain cases, Anthem may approve Benefits for transportation to a facility that is not the nearest facility.

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

If You receive Out-of-Network ambulance services, Anthem will pay eligible Benefits directly to the Out-of-Network ambulance service Provider or issue a check payable to You and the ambulance service Provider, subject to the terms and conditions of this Plan. If You receive such a bill, please contact Anthem Member Services before You pay the bill.

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

Other noncovered ambulance services include, but are not limited to, trips to:

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

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

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

Air ambulance will not be covered if You are taken to a hospital that is not an acute care hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if You are taken to a Provider's office or Your home.

F. Virtual Visits (Telemedicine/Telehealth Visits). Virtual Visits (Telemedicine/Telehealth Visits) are covered for Medically Necessary physical medicine and mental health visits that are appropriately provided through interactive electronic communications and information technology. Services include the use of live (synchronous) secure videoconferencing or voice as well as the use of audio, video or other electronic media used for the purpose of diagnosis, consultation, care management and self-management or treatment.

In person contact between a health care Provider and the patient is not required for these services and the type of setting where these services are provided is not limited.

Remote patient monitoring services using telecommunications technology to enhance the delivery of home health care are also covered, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

Telemedicine does not include the use of facsimile, texting, electronic mail or non-secure instant messaging.

Please note: Not all services can be delivered through Virtual Visits. Certain services require equipment and / or direct physical hands-on care that cannot be provided remotely. Also, not all Providers offer virtual visits. Services not appropriate for Virtual Visits include services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely. Except as stated above, no Benefits are available for Virtual Visits (Telemedicine/Telehealth Visits).

G. **Home Visits.** Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Provider visits in the home are different than the "Home Health Care Services" benefit described later in this Section.

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. Any combination of physical, occupational or speech therapy visits count toward this limit.

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.

Covered Services for speech therapy are limited to:

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

Benefits are available for physical, occupational and speech therapy services intended to develop skill or function or to prevent the loss of attained skill or function for Members with pervasive developmental disorder or autism. Covered Services to treat pervasive developmental disorder or autism are not subject to, and do not count toward, any applicable visit limits shown on Your Cost Sharing Schedule for Outpatient physical, occupational and speech therapy. See Section 7, VI, I, "Autism Services" for more information. Physical, occupational and speech therapy services must require the direct intervention, skilled knowledge and attendance of a licensed physical, occupational or speech therapist.

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. No Benefits are available for sport, recreational or occupational reasons.

Except as stated in Section 7, VI, I, "Autism Services" and in Section 7, III, D, "Early Intervention Services," the following limitations and exclusions apply:

- 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 Provider and by Anthem. Services must provide significant improvement within a reasonable and generally predictable period of time. Noncovered services include, but are not limited to: ongoing or life-long exercise and education programs intended to maintain fitness, voice fitness or to reinforce lifestyle changes, including but not limited to lifestyle changes affecting the voice. Such ongoing services are not covered, even if ordered by Your Provider or supervised by skilled program personnel.

- No Benefits are available for Developmental Disabilities.

Please see article VI, A, "Dental Services" for Benefit information about physical therapy for treatment of TMJ disorders.

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 the telephone number on Your identification card to determine program eligibility.

Covered Services include medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). No Benefits are available for home programs, on-going conditioning, or maintenance care.

C. **Chiropractic Care**. 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:

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

- 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; and

- 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 Provider.

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 article.

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 related to early intervention services are not subject to, and do not count toward, any applicable visit limits shown on Your Cost Sharing Schedule for Outpatient physical, occupational and speech therapy.

E. **Post-cochlear implant aural therapy.** Post-cochlear implant aural therapy services are covered for eligible Members to help a person understand the new sounds they hear after getting a cochlear implant.

F. **Cognitive Rehabilitation Therapy.** Cognitive Rehabilitation Therapy services are covered for eligible Members only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.

IV. Home Health Care Services

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

A. **Provider Services.** Benefits are available for Provider 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 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:

- Part-time or intermittent skilled nursing care by (or under the supervision of) a Registered Nurse.
- Part-time or intermittent home health aide services that consist primarily of caring for You under the supervision of a Registered Nurse.
- Prenatal and postpartum homemaker visits. Homemaker visits must be Medically Necessary. For example, if You are confined to bed rest or Your activities of daily living are otherwise restricted by order of Your Network Provider, prenatal and/or postpartum homemaker visits may be considered Medically Necessary. When determining the Medical Necessity of such services, Anthem's case manager will consult with Your Provider.
- Physical, occupational, or speech therapy. Therapy provided by a Home Health Agency does not count toward any annual limits that may apply to article III, A (above).
- 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.
- Nutrition counseling provided as part of a covered home health plan. The nutrition counselor must be a registered dietitian employed by the covered Home Health Agency.

C. **Hospice.** Hospice care is home management of a terminal illness. You are eligible for hospice care if Your Provider and the hospice medical director certify that You are terminally ill and likely have less than 12 months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying 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 Referral and Precertified by Anthem or the appropriate Local Plan;
- 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 or the appropriate Local Plan, provided that the Out-of-Network Provider is a BlueCard Provider;
- The patient must have a terminal illness with a life expectancy of 12 months or less, as certified by a Provider;
- 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 Provider and medical team must support hospice

care because it is in the patient's best interest; and

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

The hospice Provider and Anthem (or the appropriate Local Plan) will establish an individual hospice plan that meets Your individual needs. Each portion of a hospice plan must be Medically Necessary and specifically Precertified by Anthem or the appropriate Local Plan. Otherwise, no Benefits are available. Covered Services that may be part of the individual hospice plan are:

- Skilled nursing visits;
- Home health aide and homemaker services;
- Physical therapy for comfort measures. These therapy services do not count toward annual limits that may apply to article III, A of this Section;
- Social service visits;
- Durable medical equipment and medical supplies;
- Respite care (in the home) to temporarily relieve the primary caregiver from care-giving functions;
- Continuous care, which is additional respite care to support the family during the patient's final days of life;
- Short-term Inpatient hospital care when needed in periods of crisis or as respite care; and
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver, and individuals with significant personal ties, for one year after the Member's death.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in hospice. These services are Covered Services under other parts of the Plan.

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

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

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

Benefits may be subject to Deductible and/or Coinsurance, as shown on 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.

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;
- Useful only for the specific illness or injury that Your Provider has diagnosed or suspects;
- Non-disposable and specifically designed and intended to withstand repeated use; and
- Meant for use outside a medical facility.

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 external insulin infusion pumps for insulin dependent diabetics. External insulin pumps must be approved *in advance* by Anthem. To determine eligibility, please ask Your Provider to contact Anthem for Prior Approval *before* You purchase the pump. Anthem will require treatment and clinical information in writing from Your Provider. Anthem will review the information and determine in writing whether the services are covered under this Certificate, based on the criteria stated in this Certificate and Anthem's guidelines for external infusion pumps. You may contact Anthem to request a copy of Anthem's internal guidelines, or log in to Your secure account at *www.healthtrustnh.org* and click on the Anthem button. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate and Your Cost Sharing Schedule. Please see article II, A, 13 of this Section for information about external insulin pump education. Implantable insulin infusion pumps are not covered.

Benefits are also available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. Foot orthotics (orthopedic shoes or footwear or support items) are not covered unless used for systemic illness affecting the lower limbs, such as severe diabetes.

Benefits are also available for bone-anchored hearing aids and cochlear implants. Hearing aids are covered as stated in article VI, B, "Hearing Services." Benefits are limited to one hearing aid per ear each time a hearing aid prescription changes or one hearing aid per ear as needed every 60 months, whichever occurs first. Please see article VI, B for more information.

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 Provider 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 Plan includes a Prescription Eyewear Rider with this Certificate, 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, glucose monitors, test strips and lancets.
- **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. To be eligible for Benefits, Your Provider must issue a written order stating that the enteral formula and/or food product is:

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

Otherwise, no Benefits are available. Any Deductible and/or Coinsurance stated on Your Cost Sharing Schedule specifically for Durable Medical Equipment, Medical 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 on Your Cost Sharing Schedule for medical supplies under "Outpatient Services."

3. **Prosthetics.** Benefits are available for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. 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. Covered Services may include, but are not limited to:

- Artificial limbs and accessories. Artificial limbs are prosthetic devices that replace, in whole or in part, an arm or leg; with respect to members under the age of 19, coverage will also be provided for one activity-specific prosthetic device per plan year. Your Provider will determine the most appropriate model that meets the medical needs of the Member;
- Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health Cancer Rights Act;
- Restoration prosthesis (composite facial prosthesis); and
- Scalp hair prosthesis. 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. To be eligible for Benefits for scalp hair prostheses, Your Provider must state in writing that the prosthesis is Medically Necessary. You must submit Your Provider's statement with Your claim.

  You pay no Copayment, Deductible or Coinsurance for covered scalp hair prostheses. Any Deductible or Coinsurance stated on Your Cost Sharing Schedule for Durable Medical Equipment, Medical Supplies and Prosthetics does not apply to scalp hair prostheses.

  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 article E:

- Whether an item is purchased or rented, Benefits are limited to the Maximum Allowed Amount. Benefits will not exceed the Maximum Allowed Amount 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 Allowed Amount for the least expensive service and the charge for the more expensive service.

- If You rent or purchase equipment and Benefits are paid equal to the Maximum Allowed

Amount, no further Benefits will be provided for rental or purchase of the equipment.

- Anthem is given the right to determine if equipment should be rented instead of purchased. For example, if Your Provider prescribes a hospital bed for short-term home use, 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 would be paid for rental, even if You purchase the equipment. You will be responsible for paying the difference between the Maximum Allowed Amount for rental and the charge for purchase.

- Burn garments (or burn anti-pressure garments) are covered only when prescribed by Your Provider 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 Provider and are Medically Necessary, as defined in Section 14.
  Anti-embolism stockings are not covered. Inelastic compression devices are not covered. The Maximum Allowed Amount for covered gradient pressure aids includes the Benefit for fitting of the garments. No additional Benefits are available for fitting.

- 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 article VI, G, "Surgery" below in this Section. To be eligible for Benefits, an 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.

- Benefits are available for broad or narrow band ultraviolet light (UVB) home therapy equipment only if the therapy is conducted under a Provider'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. Please see Section 8, I, "Ultraviolet Light Therapy and Ultraviolet Laser Therapy for Skin Disorders," for information about out-of-home ultraviolet light therapy.

5. **Exclusions.** In addition to the other limitations and exclusions stated in Section 8, the following services and supplies are not covered. These exclusions apply even if the services or supplies are provided, ordered or prescribed by a Provider and even if the services or supplies meet the definition of Medical Necessity found in Section 14.

   No Benefits are available for:

   - Foot orthotics (orthopedic shoes or footwear or support items), unless used for systemic illness affecting the lower limbs, such as severe diabetes.

   - 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.

   - Sports glasses, sports bras, nursing bras and maternity girdles or any other special clothing, except as stated in this article.

- Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as Covered Services.

- Bath seats or benches (including transfer seats or benches), whirlpools or any other bathtub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans.

- Heat lamps, heating pads, hydrocollator heating units, hot water bottles, batteries and cryo cuffs (water circulating delivery systems).

- Biomechanical limbs (except as otherwise indicated in this Certificate), 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, but not limited to, hats, belts, harnesses, safety 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 (except as stated in 2 "Medical Supplies" above), TENS units for incontinence, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for websites or software, or any other media instruction or for any other educational or instructional material, technology or equipment.

- Dentures, orthodontics, dental prosthesis and appliances.

- Convenience and personal care services and supplies. Please see Section 8, II, "Convenience and Personal Care" for more information.

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss / theft.

- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

- Non-Medically Necessary enhancements to standard equipment and devices.

- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Except as specified in this article and in any amendment to this Certificate, no Benefits are available for the cost of Durable Medical Equipment, Medical Supplies, or Prosthetics.

V. Behavioral Health Care (Mental Health and Substance Use Care)

A. **Behavioral Health Care.** Benefits are available for Medically Necessary Behavioral Health Care. Behavioral Health Care means the Covered Services described in this article for diagnosis and treatment of Mental Disorders and Substance Use Disorders as defined below.

- **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. The term "Mental Disorder" 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).

Mental Disorders include:

- Schizophrenia and other psychotic disorders such as, but not limited to, paranoia
- Schizoaffective disorder
- Major depressive disorder
- Bipolar disorder
- Obsessive compulsive disorder
- Pediatric autoimmune neuropsychiatric disorder
- Panic disorder
- Anorexia nervosa
- Bulimia nervosa
- Chronic post-traumatic stress disorder
- Pervasive developmental disorder or autism. Pervasive developmental disorders are defined in the most current version of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association to include autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

- **A Substance Use Disorder** 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 Use Disorder under the terms of this Certificate.

In determining whether or not a particular condition is a Mental Disorder or Substance Use Disorder, 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.

B. **Covered Services.** Benefits are available for the following Covered Services. Covered Services must be furnished by an Eligible Behavioral Health Provider, as defined in C below. Your PCP may refer You to a Network Behavioral Health Provider, but Referrals are not required for Network Behavioral Health Providers. Out-of-Network Services require a PCP Referral in advance and may also require Preauthorization. Cost sharing amounts for Behavioral Health Care Covered Services are shown on Your Cost Sharing Schedule.

1. **Outpatient Services/Office Visits.** Covered Services include diagnosis and evaluation, therapy and treatment, medication checks, detoxification, rehabilitation, and psychological testing, including but not limited to Medically Necessary psychological testing for bariatric surgery candidates. Benefits are also available for Partial Hospitalization and Intensive Outpatient Programs (sometimes called "day/evening" programs).

   Outpatient/office visits are covered for Medically Necessary treatment of pervasive developmental disorder or autism, including applied behavioral analysis. Please see Section 7, VI, I, "Autism Services" for more information.

   Outpatient services may be provided in an office, through Virtual Visits, or in an outpatient department of a hospital or other covered Outpatient facility, such as for a Partial Hospitalization Program or Intensive Outpatient Program (day treatment program). See Section 7, II, F, "Virtual Visits (Telemedicine/Telehealth Visits)" for more information about telemedicine services and Virtual Visits.

2. **Virtual Visits.** Covered Services include Virtual Visits as described under the "Virtual Visits (Telemedicine/Telehealth Visits)" in Section 7, II, F.

3. **Inpatient Services.** Covered Services include Medically Necessary services in a hospital or other facility typically provided as part of an Inpatient admission for treatment of Mental Disorders or Substance Use Disorders. Benefits include psychotherapy, psychological testing, electroconvulsive therapy, detoxification, and rehabilitation. For treatment of Substance Use Disorders, Benefits include clinical stabilization services and short-term Inpatient withdrawal management.

Emergency Room Boarding in New Hampshire Hospitals. Following the completion of an involuntary admission certificate for a Member, the Plan will cover board and care for the Member waiting in an Emergency Department of an acute care hospital located in the State of New Hampshire for each day the Member is waiting for admission for psychiatric treatment to the New Hampshire State Hospital, a community-based designated receiving facility, or a voluntary admission, for up to 21 consecutive days or more until discharged.

4. **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:

   - Observation and assessment by a Provider weekly or more often; and
   - Rehabilitation and therapy.

C. Eligible Behavioral Health Providers. As approved by Anthem, Eligible Behavioral Health Providers from whom You can receive Covered Services for Behavioral Health Care include, without limitation, the following:

- Psychiatrist
- Licensed psychologist
- Neuropsychologist
- Licensed clinical social worker
- Psychiatric Advanced Practice Registered Nurse
- Licensed marriage and family therapist
- Licensed clinical mental health counselor
- Licensed alcohol and drug abuse counselor
- Community Mental Health Center
- Licensed pastoral psychotherapist
- For the treatment of pervasive developmental disorder or autism, an individual who is professionally certified by a national board of behavior analysts or who is under the supervision of a person professionally certified by a national board of behavior analysts
- Short Term General Hospital
- Residential Treatment Center
- Private or Public Hospital
- Partial Hospitalization or Intensive Outpatient Program (day treatment program)
- Substance Use Disorder Treatment Provider
- Any of the above unlicensed Providers who possess at least a master's level education and is permitted by the respective New Hampshire professional licensing law to practice under the supervision of a qualified New Hampshire licensee and who is actively pursuing a professional licensure.

VI. Important Information About Other Covered Services

This article includes other services that are covered and often involve Covered Services defined elsewhere in this Section. For example, the Human Organ and Tissue Transplant Services described in D below involve Inpatient and Outpatient services described throughout articles I, "Inpatient Services" and II, "Outpatient Services" (above in this Section).

The limitations and exclusions stated in this article are in addition to those stated in Section 8. Limitations and exclusions apply even if You receive services from Your Provider or according to Your Provider's order or according to the recommendation of another Provider and even if the service meets the definition of Medical Necessity. No Benefits are available for any services performed in conjunction with, arising from, or as a result of complications of a noncovered service. All of the Plan rules, terms and conditions stated elsewhere in this Certificate apply to the services in this article.

A. Dental Services

The following dental services are covered:

1. **Treatment of Accidental Injury to Sound Natural Teeth.** Benefits are available for Medically Necessary dental services resulting from an accidental injury to sound natural teeth and gums when the course of treatment for the accidental injury is authorized by Anthem. Medically Necessary treatment due to injury to

the jaw and oral structures other than teeth shall also be covered when authorized by Anthem. Cost sharing amounts for Covered Inpatient and Outpatient Services are shown on Your Cost Sharing Schedule.

No Benefits are available for diagnosis or treatment if You damage Your teeth, supporting structure or appliances as a result of biting or chewing unless the biting or chewing results from a medical or mental condition. No Benefits are available to repair, restore or replace items such as fillings, crowns, caps or appliances.

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

a. Surgical removal (extraction) of erupted teeth before radiation therapy for malignant disease. Services must be 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 surgeon; and
- General anesthesia furnished by a licensed anesthesiologist or anesthetist who is not the 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 removal of bone impacted teeth and gingivectomy. Services must be furnished by a Network Provider. Otherwise, no Benefits are available. Benefits are limited to:

- The surgeon's fee for the surgical procedure;
- General anesthesia furnished by an anesthesiologist who is not the operating dentist or oral surgeon; and
- Gingivectomy is limited to excision of the soft tissue wall of the "pocket," up to four quadrants per lifetime.

Regarding a and b above: No Benefits are available for related preoperative or postoperative care, including medical, laboratory and x-ray services.

No Benefits are available for local anesthesia services by the surgeon, surgical exposure of impacted teeth to aid eruption, osseous and flap procedures in conjunction with gingivectomy or any other services for periodontal disease (such as scaling and root planing, prophylaxis and periodontal evaluations). No Benefits are available for facility fees, unless the provisions of 4 below apply.

c. 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 article) 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 furnished by a Network Provider. Otherwise, no Benefits are available.

Cost sharing amounts for covered oral surgery, anesthesia, office and facility care are shown on Your Cost Sharing Schedule.

3. **Diagnosis and Surgical Correction or Repair of the Temporomandibular Joint (TMJ).** Benefits are available for medical exams and diagnostic x-rays of the temporomandibular joint (TMJ) and other facial bones to diagnose TMJ disorder. 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. Services must be furnished by a Network Provider. 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 on Your Cost Sharing Schedule.

Except as stated in this article, no Benefits are available for diagnosis, evaluation or treatment of the TMJ. Diagnostic arthroscopy for TMJ disorders and trigger point injections are not covered. Except as stated in this

article, no Benefits are available for non-surgical TMJ services, 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 whose dental condition is 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 covered Inpatient and Outpatient facility charges and for general anesthesia are shown on Your Cost Sharing Schedule. No Benefits are available for a noncovered dental procedure, even when Your Provider 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 through 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 and 4 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 Allowed Amount for surgery includes the Benefit payment for IV sedation and/or local anesthesia. For any surgical dental service covered under this article, no Benefits beyond the surgical Maximum Allowed Amount 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 planing, prophylaxis and periodontal evaluations are not covered even if they are furnished in conjunction with a covered gingivectomy.

   d. No Benefits are available for preventive dental services.

   e. Except as stated in 1 and 4 above, 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 Provider and Anthem authorize hospitalization and general anesthesia covered under this article.

   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, TMJ appliances, splints or guards, 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 article, no Benefits are available for office services, anesthesia services or facility fees. Except as stated in 4 above, 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

In addition to routine hearing exams covered under article II, A, "Preventive Care," Benefits are available for Inpatient and Outpatient services to diagnose and treat ear disease or injury. Benefits are also available for the professional services of a hearing care professional or hearing instrument dispenser for the fitting, dispensing, servicing, or sale of hearing aids as stated in "Hearing Aids" below. Cost sharing amounts are shown on Your Cost Sharing Schedule.
Your Network Provider must find or suspect injury to the ear or a diseased condition of the ear, or that hearing aids are Medically Necessary. Otherwise, no Benefits are available. For example, Benefits are available for laboratory hearing tests furnished by a Network Audiologist, provided that Your Network Provider finds or suspects injury to the ear or a diseased condition of the ear.

Hearing Aids. Benefits are available for one hearing aid per ear each time a hearing aid prescription changes or one hearing aid per ear as needed every 60 months, whichever occurs first.

"Hearing aid" means any instrument or device, including bone-anchored hearing aids and cochlear implants, designed, intended, or offered for the purpose of improving a person's hearing and any parts, attachments, or accessories, including ear molds. Hearing aids must be approved in advance by a Network Provider and furnished by a Network Provider. Otherwise, no Benefits are available. A hearing aid must be prescribed, fitted, serviced and dispensed by a Network Audiologist or other Network Provider who is a hearing instrument dispenser or other hearing care professional. Otherwise, no Benefits are available.

A hearing care professional is a person who is a licensed audiologist, a licensed hearing aid dispenser, or a licensed Provider.

A hearing instrument dispenser is a person who is a licensed hearing care professional who engages in the selling, practice of fitting, selecting, recommending, dispensing, or servicing of hearing aids or the testing for means of hearing aid selection or who advertises or displays a sign or represents himself or herself as a person who practices the testing, fitting, selecting, servicing, dispensing, or selling of hearing aids. The "practice of fitting, dispensing, servicing, or sale of hearing aids" means the measurement of human hearing with an audiometer, calibrated to the current American National Standard Institute standards for the purpose of making selections, recommendations, adoptions, services, or sales of hearing aids including the making of ear molds as a part of the hearing aid.

Hearing aids furnished by a licensed durable medical equipment (DME) Provider are subject to the cost sharing amounts shown on Your Cost Sharing Schedule for DME, and are subject to the terms and conditions of Section 7, IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics." When hearing aids are furnished by a Provider who is not a licensed DME Provider, Covered Services are subject to the same cost sharing amounts as shown on Your Cost Sharing Schedule for medical supplies under "Outpatient Services."

Charges for batteries, cords, and individual or group auditory training devices and any instrument or device used by a public utility in providing telephone or other communication services are not covered.

Benefits for hearing aids are limited to the Maximum Allowed Amount. Benefits will not exceed the Maximum Allowed Amount 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 Allowed Amount for the least expensive service and the charge for the more expensive service.

C. Infertility Services

Benefits are available for the Infertility Services listed in this article. To be eligible for Benefits, Covered Services

must be Medically Necessary. Coverage is not available to partners who are not Members. Benefits are subject to cost sharing amounts as shown on Your Cost Sharing Schedule.

For the purposes of determining Benefit availability, "Infertility," which may occur in either a male or female, is defined as the inability to become pregnant or to carry a pregnancy to live birth, or the inability to cause pregnancy and live birth, in accordance with guidelines developed by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology or the Society for Assistive Reproductive Technology.

Male infertility may include but is not limited to blockage of the seminal tract, a congenital absence or congenital obstruction of the vas deferens, or low sperm motility or quantity. Please note that menopause in a woman is considered a natural condition and is not considered "Infertility" as defined in this Certificate.

1. **Covered Services** include Medically Necessary diagnostic tests to find the cause of Infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis, as well as well as fertility drugs or hormones administered in a Provider's office or other Outpatient setting. The Medical Necessity of Covered Services is based upon guidelines established by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology or the Society for Assistive Reproductive Technology.
   Medically Necessary Covered Services, as recognized by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology or the Society for Assistive Reproductive Technology as a cause of Infertility, will include, but will not be limited to:

   - Intracervical or Intrauterine Artificial Insemination (AI).
   - Assisted Reproductive Technology (ART) such as, In-vitro fertilization and Embryo Transfer (IVF-ET), Gamete Intra-fallopian Transfer (GIFT), or Zygote Intra-fallopian Transfer (ZIFT).
   - Cryopreservation of embryos, eggs, sperm and reproductive material that is not Experimental or Investigational, when provided as part of an active, covered artificial insemination procedure or ART cycle.
   - Preservation of fertility when a Member is expected to undergo surgery, radiation, chemotherapy or other medical treatment: Storage of cryopreservation material shall begin at the time of the cryopreservation and will continue provided the Member continues to be covered under this Plan.

   Precertification must be obtained for all Covered Services relating to Infertility treatment.

2. **Exclusions.** In addition to the Exclusions stated in Section 8, II, no Benefits are available for the following:

   - The preparation or introduction of embryos, oocytes, or donor sperm for surrogates or gestational carriers.
   - Any service that is an Experimental or Investigational Service, as defined in Section 8, II.
   - Non-medical costs related to third party reproduction.
   - Services related to reversal of voluntary sterilization.

If You have questions about Benefit eligibility for a proposed Infertility Service, You are encouraged to contact Anthem *before* You receive the service. Your Provider 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 but not limited to, Copayment, Deductible, and Coinsurance requirements, and the limitations, exclusions, network restrictions, other party liability rules and eligibility/enrollment rules stated in this Certificate.

You have the right to appeal Benefit determinations made by Anthem, including Adverse Benefit Determinations regarding coverage for Infertility Services. Please see Section 11 for more information.

D. Human Organ and Tissue Transplant Services

Benefits are available for Medically Necessary human solid organ and tissue transplants according to the terms of

this article. Transplants are covered like any other surgery, under the regular Inpatient and Outpatient Benefits described elsewhere in this Certificate. Benefits are subject to the cost sharing amounts shown on Your Cost Sharing Schedule.

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

1. **Covered Services.** The following transplant procedures and related services are covered if all of the conditions stated in this article are met:

    - Any Medically Necessary human solid organ, tissue, and stem cell/bone marrow transplants and infusions including necessary acquisition procedures, mobilization, collection and storage.

    - Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

2. **Prior Approval and Precertification.** To maximize Your benefits, You should call Anthem's Transplant Department as soon as You think You may need a transplant to talk about Your Benefit options. You must do this before You have an evaluation and/or work-up for a transplant. Anthem will help You maximize Your Benefits by giving You coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, or exclusions apply. Call Anthem Member Services at the telephone number on Your identification card and ask for the transplant coordinator. Even when Anthem gives a Prior Approval for the covered transplant procedure, You or Your Provider must call Anthem's Transplant Department or the Local Plan for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

    Your Provider must certify, and Anthem or the Local Plan must agree that the transplant is Medically Necessary. Please see Section 14 for the definition of Medical Necessity. Your Provider should send a written request for Precertification to Anthem or the Local Plan as soon as possible to start this process. If Anthem or the Local Plan notifies You that the transplant is not approved and You decide to receive the services, no Benefits will be available. If You or Your Provider do not contact Anthem or the Local Plan for Precertification as required and Anthem or the Local Plan later determines that the transplant was not Medically Necessary, no Benefits will be available.

    Please note that there are cases where Your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor screening and/or a collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor screening charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor screening and/or collection and storage is not an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

3. **Donor Benefits.** Benefits for an organ donor are as follows:

    - When the organ donor is not a Member, Benefits under this Plan are limited to Benefits not available to the donor from any other source. This includes, but is not limited to, other health insurance or health plan coverage, grants, foundations, and government programs.

    - If a Member is donating the organ to someone who is not a Member, no Benefits are available under this Plan for the donor or recipient, except for HLA testing. HLA testing is covered for Members who undergo the testing for the purposes of participating in the National Marrow Donor Program, provided that:

        - The Member meets the criteria for testing established by the National Marrow Donor program;

        - The Member completes and signs an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program;

        - The Member acknowledges a willingness to be a bone marrow donor if a suitable match is

found; and

- The screening is furnished by a Network Provider acting within the scope of the Provider's license.

An HLA test is a human leukocyte antigen laboratory test, also referred to as a histocompatibility locus antigen laboratory test. Benefits for HLA testing are limited to the Maximum Allowed Amount as allowed by law. New Hampshire law prohibits Providers from billing Members for the difference between the Maximum Allowed Amount and the Provider's charge.

4. **Travel Costs.** Benefits are available for a transplant recipient for transportation, lodging and meal costs for the patient and one other individual to travel to and from the site for the transplant surgery. If the transplant recipient is a minor, transportation, lodging and meal costs are extended to two other individuals. Total transportation, and reasonable and necessary lodging and meal costs, not to exceed $150 per day, are not to exceed a maximum of $10,000 for the patient and all accompanying individuals for each completed covered transplant.

E. Clinical Trials

Benefits are available for Medically Necessary services, such as routine patient care costs, provided to You as a participant in an approved clinical trial if the services are Covered Services under this Plan. You may be required to use a Network Provider to maximize Your Benefits.

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

1. Federally funded trials approved or funded by one of the following:

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

2. Studies or investigations done as part of an Investigational new drug application reviewed by the Food and Drug Administration.

3. Studies or investigations done for drug trials which are exempt from the Investigational new drug application.

Routine patient care costs include items, services, and drugs provided to You in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including services that are not part of approved clinical trials, will be reviewed according to Anthem's clinical coverage guidelines, related policies and procedures. Your Plan is not required to provide Benefits for the following services. The Plan reserves the right to exclude any of the following:

- The Investigational item, device, or service;

- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and

- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

F. Required Exams or Services

Court ordered examinations or services are covered, provided that:

- The services are Medically Necessary Covered Services furnished by a Provider; and

- All of the terms and conditions of this Certificate are met.

Benefits are subject to the cost sharing amounts on Your Cost Sharing Schedule.
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 Provider 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 this Section 7.

G. Surgery

Benefits are available for surgical services on an Inpatient or Outpatient basis, including office surgeries. Benefits are subject to the cost sharing amounts shown under parts I and II of Your Cost Sharing Schedule.
Covered Services include:

- Accepted operative and cutting procedures;

- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;

- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;

- Treatment of fractures and dislocations;

- Anesthesia and surgical support when Medically Necessary; and

- Medically Necessary pre-operative and post-operative care.

Under the terms of this article, 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 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 as well as surgery and reconstruction of the other breast (to produce a symmetrical appearance) in the manner chosen by the patient and the Provider.

   Otherwise, 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;

   - Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury;

- Necessary to restore or improve a bodily function; or

- Necessary to correct significant deformities caused by congenital or developmental abnormalities, illness, injury, an earlier treatment, and to improve bodily function or symptoms or to create a normal appearance.

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.

Benefits are available based on the criteria stated in this Certificate. Please see article 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.

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

3. **Dental Services.** Dental services are covered only as stated in article VI, A, "Dental Services." Except as stated above in A, 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. The definition of Medical Necessity is found in Section 14. 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 Provider or performed or ordered by another Provider. This exclusion applies even if the surgery, service or program meets the definition of Medical Necessity. Except as stated in this article, no Benefits are available for bariatric surgery or any other surgery intended to manage or control appetite or body weight.

Please see articles II, A, 7, "Nutritional Counseling," II, A, 13, "Diabetes Management Programs" and V, "Behavioral Health Care," subsection B, "Covered Services," for information about Benefits for non-surgical services for weight management, management of obesity and treatment of the diseases and ailments caused by or resulting from obesity.

5. **Postoperative Medical Care.** Postoperative medical care is the medical care related to and provided after the surgery. The Maximum Allowed Amount for surgery includes the Benefit payment for postoperative medical care. No Benefits beyond the surgical Maximum Allowed Amount are available for surgery-related postoperative medical care.

6. **Human Organ and Tissue Transplant Surgery.** Please see article VI, D, "Human Organ and Tissue Transplant Services" above for important information about coverage and limitations for organ and tissue transplant surgery.

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

8. **Gender Affirming Services.** Benefits are available for gender affirming surgery and hormone treatments for Members diagnosed with Gender Dysphoria. To be eligible for benefits, services must be Medically Necessary and all inpatient facility admissions must be approved in advance through Precertification. Some conditions may apply, and all services must be Precertified by Anthem as outlined in Section 5, "About Managed Care."

9. **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 Provider and meets the 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 Provider 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 but not limited to Copayment, Deductible, and Coinsurance requirements, and the limitations, exclusions, network restrictions, other party liability rules and eligibility/enrollment rules stated in this Certificate.

H. Vision Services

Benefits are available for the diagnosis and treatment of eye disease or injury. Covered Services (Inpatient and Outpatient care) are described throughout this Section 7. To be eligible for Benefits, these services must be provided by a Network Provider or according to a Referral and may require Anthem's Precertification for Out-of-Network Services. Benefits are subject to the cost sharing amounts as shown on Your Cost Sharing Schedule.

Except as stated in article II, A, 12, no Benefits are available for routine vision care to determine the need for vision correction or for the prescription and fitting of corrective, including contact, lenses. No Benefits are available for services, supplies or charges for eye surgery to correct errors of refraction, such as near-sightedness, including, without limitation, radial keratotomy and PRK Laser (photo refractive keratectomy) or excimer laser refractive keratectomy.

Unless Your Plan includes a Prescription Eyewear Rider with this Certificate, eyewear (frames, lenses and contact lenses) is covered for medical conditions only as stated in article IV, E, 2, "Medical Supplies."

No Benefits are available for vision therapy including, without limitation, treatment such as vision training, orthoptics, eye training, or eye exercises.

I. Autism Services

Benefits are available for Medically Necessary treatment of pervasive developmental disorder or autism. To determine the Medical Necessity of services, Anthem may require submission of a treatment plan signed by the Member's Primary Care Provider (PCP), an appropriately credentialed treating specialist, a child psychiatrist, a pediatrician with a specialty in behavioral-developmental pediatrics, a neurologist with a specialty in child neurology or a licensed psychologist with training in child psychology. Anthem will review the treatment plan no more than once every six months unless the Member's Provider changes the treatment plan. See Section 14 for the definition of Medical Necessity.

Covered Services include:

1. Direct or consultative services provided by a licensed professional including a licensed psychiatrist, licensed Advanced Practice Registered Nurse, licensed psychologist, licensed clinical social worker or by the Providers identified under the Behavioral Health Care section of this Certificate.

2. Physical, occupational and speech therapy provided by a licensed physical or occupational therapist or by a licensed speech therapist to develop skill or function or to prevent the loss of attained skill or function. Covered Services to treat pervasive developmental disorder or autism are not subject to, and do not count toward, any applicable visit limits shown on Your Cost Sharing Schedule for Outpatient physical, occupational and speech therapy.

3. Applied behavioral analysis that is Medically Necessary to treat pervasive developmental disorder or autism. Applied behavior analysis means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Applied behavior analysis must be furnished by an individual who is professionally certified by a national board of behavior analysts or the services must be performed under the supervision of a person professionally certified by a national board of behavior analysts. Otherwise, no Benefits are available for applied behavior analysis.

SECTION 8: LIMITATIONS AND EXCLUSIONS

Please see Section 14 for Definitions of specially capitalized words.

I. Limitations

The following are important limitations that apply to the Covered Services stated in Section 7. 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 article are limited as indicated below. Limitations apply to these items and services even if You receive them from Your PCP or Network Provider or according to a Referral from Your PCP or Network Provider.

Please remember, this 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 with respect to that service are not covered. Anthem is given the right to determine if services or supplies are Covered Services.

Determinations about Referrals, Precertification, Medical Necessity, Experimental or Investigational Services, and new technology are based on the terms of this Certificate, including but not limited to the definition of Medical Necessity found 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 Benefit Determinations regarding Medical Necessity. Please see Section 11 for more information about the appeal process.

Growth Hormone Treatment. No Benefits are available for any growth hormone treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones) solely to increase or decrease height or alter the rate of growth, except:

- Self-administered human growth hormones 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.

Human growth hormones must be authorized *in advance* by Your child's Provider and must be approved for Medical Necessity by Anthem. Please call the telephone number on Your identification card for approval. Benefits are subject to the cost sharing amounts as shown in part II of Your Cost Sharing Schedule for medical supplies.

Private Room. If You occupy a private room, You will have to pay the difference between the hospital's charges for a 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 Network Provider must provide Anthem or the Local Plan with a written statement *in advance* regarding the Medical Necessity of Your use of a private room, and Anthem or the Local Plan must agree *in advance* that private room accommodations are Medically Necessary. Benefits are subject to the cost sharing amounts as shown in part I of Your Cost Sharing Schedule.

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.

Please see Section 7, IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about coverage for Medically Necessary equipment and supplies for home ultraviolet light therapy for skin disorders.

Except as stated in Section 7 and in this article, no Benefits are available for ultraviolet light therapy or ultraviolet laser therapy for skin disorders. This limitation applies even if the therapy is furnished, prescribed, or supervised by a Provider and even if the therapy meets the definition of Medical Necessity.

II. Exclusions

Benefits are not available for the following items or services, unless required by federal law. In addition to other limitations, conditions and exclusions set forth elsewhere in this Certificate, no Benefits will be provided for expenses related to services, supplies, conditions or situations described in this article. These items and services are not covered even if provided by Your Network Provider or according to a Referral from Your PCP.

Please remember, this Plan does not cover any service or supply not specifically listed as a Covered Service in this Certificate. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem is given the right to determine if services or supplies are Covered Services.

Alternative or Complementary Medicine. No Benefits are available for services or supplies for alternative or complementary medicine, even if the service or supply is recommended by Your Provider and is 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 the definition of Medical Necessity as stated in Section 14. Services or supplies for alternative or complementary medicine include, but are not limited to:

- Acupuncture (unless Your Plan includes an Acupuncture Endorsement with this Certificate)
- Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body
- Holistic medicine
- Homeopathic medicine
- Hypnosis
- Aroma therapy
- Massage and massage therapy, except for massage therapy services that are part of a physical therapy treatment plan and covered under the "Outpatient Physical Rehabilitation Services" section of this Certificate.
- Reiki therapy
- Herbal, vitamin or dietary products or therapies
- Thermography
- Orthomolecular therapy
- Contact reflex analysis
- Bioenergetic synchronization technique (BEST)
- Iridology-study of the iris
- Auditory integration therapy (AIT)
- Colonic irrigation
- Magnetic innervation therapy
- Electromagnetic therapy
- Neurofeedback / Biofeedback

Amounts That Exceed the Maximum Allowed Amount. Benefits for Covered Services are limited to the Maximum Allowed Amount. As stated in this Certificate, You may be responsible for any amount that exceeds the Maximum Allowed Amount. See Sections 9, I and 14 for the definition of Maximum Allowed Amount.

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. Your immediate family is defined to include parents, siblings, spouses, children, grandparents, in-laws, and You.

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 Your coverage or after Your coverage ends, except as specifically stated in this Certificate.

If an Inpatient admission began before the effective date of Your coverage under this Certificate, Benefits will be provided under this Certificate for Inpatient days occurring on or after the effective date of Your coverage under this Certificate, unless this coverage replaces that of another carrier and the term of the prior carrier's policy provides coverage for the entire admission (admission date to discharge date).

Except as stated in Section 13, IV, "Continuation of Group 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, VI, A, "Dental Services."

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 and Personal Care. No Benefits are available for the cost of any item or service that is primarily for convenience or personal care, even if provided while You are ill or injured, under the care of a Provider, and even if the item or service is furnished, ordered or prescribed by a Provider. Items and services in this category include, but are not limited to:

- Items for personal comfort, convenience, protection, or cleanliness (such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs);
- First aid supplies and other items kept in the home for general use (such as bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads);
- Home workout or therapy equipment, including treadmills and home gyms;
- Pools, whirlpools, spas, or hydrotherapy equipment;
- Hypo-allergenic pillows, mattresses, or waterbeds;
- Residential, auto, or place of business structural changes (such as ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails); and
- Consumer wearable/personal mobile devices (such as a smartphone, smartwatch, or other personal tracking devices), including any software or applications.

Cosmetic Services. Except as stated in Section 7, VI, G, no Benefits are available for Cosmetic Services or for any care, procedures, services, equipment, or supplies provided in connection with Cosmetic Services. Cosmetic Services are meant to preserve, change, or improve how You look or are given for social reasons. Examples of Cosmetic Services include surgery or treatments to change the texture or appearance of Your skin, and surgery or treatment to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts).

Custodial Care. No Benefits are available for services, supplies or charges for Custodial Care. This includes any type of care, including room and board, that (i) does not require the skills of professional or technical workers; (ii) is not given to You or supervised by such workers or does not meet the rules for post-hospital Skilled Nursing Facility care; and (iii) is given when You have already reached the greatest level of physical or mental health and are not likely to improve further. Care can be Custodial Care even if it is recommended by a professional or performed in a facility, such as a hospital or Skilled Nursing Facility, or at home. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet;
- Changing dressings of non-infected wounds after surgery or chronic conditions;
- Preparing meals and/or special diets;
- Feeding by utensil, tube, or gastrostomy;
- Common skin and nail care;
- Supervising medicine that You can take Yourself;
- Catheter care, general colostomy or ileostomy care;
- Routine services which Anthem decides can be safely done by You or a non-medical person without the help of trained medical and paramedical workers;
- Residential care and adult day care;
- Protective and supportive care, including education; and
- Rest and convalescent care.

Developmental Disability Services. Except as stated in Section 7, III, A, "Physical Therapy, Occupational Therapy, and Speech Therapy," Section 7, III, D, "Early Intervention Services," Section 7, V, "Behavioral Health Care" and Section 7, VI, I, "Autism Services," no Benefits are available for services, counseling, therapy, supplies, equipment or programs for behavioral reasons or for Developmental Disabilities.

Disease or Injury Sustained as a Result of War, or Participation in Riot, Insurrection or Criminal Activity. No Benefits are available for care required to diagnose or treat any illness or injury that is a result of war, or participation in a riot or other act of insurrection. Unless otherwise required by law or regulation, Benefits are not available for illness or injury when the cause of the illness or injury was a Member's commission of any criminal activity.

Educational Services. No Benefits are available for services, supplies or room and board for teaching, vocational, or self-training purposes, except as specifically stated in this Certificate. This includes, but is not limited to, boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

Experimental or Investigational Services. Anthem is given the right to determine if services or supplies are Experimental or Investigational. The Plan will not pay for services or supplies which are Experimental or Investigational in nature. No Benefits are available for services related to, resulting from, arising from or provided in connection with Experimental or Investigational services, except for routine patient care costs related to certain drugs and devices that are the subject of clinical trials, as stated in Section 7, VI, E, "Clinical Trials."

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

    a. Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be 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 drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

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

        - Has been determined by the FDA to be contraindicated for the specific use;

        - 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;

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

          Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or

Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

b. Any service not deemed Experimental or Investigational based on the criteria in (a) above may still be deemed Experimental or Investigational by Anthem 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. The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under (a) and (b) above 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;
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies;
- 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;
- Documents of an IRB or other similar body performing substantially the same function;
- Consent document(s) used by the treating Providers, other medical professionals, or facilities or by other treating Providers, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
- The written protocol(s) used by the treating Providers, other medical professionals, or facilities or by other treating Providers, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

Anthem is given the authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational. Anthem's medical policy assists in Anthem's review.

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 Benefit Determinations regarding Experimental or Investigational Services. Please see Section 11 for more information.

Food and Food Supplements. No Benefits are available for foods, food supplements or for vitamins except as provided in Section 7, IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics." Please refer to that Section for information about Benefits.

Foot Care. No Benefits are available for routine foot care unless Medically Necessary. This exclusion applies to: cutting or removing corns and calluses; trimming nails; or cleaning and preventive foot care, including but not limited to (i) cleaning and soaking the feet, (ii) applying skin creams to care for skin tone, and (iii) other services that are provided when there is not an illness, injury or symptoms involving the foot.

Foot Orthotics. No Benefits are available for foot orthotics, orthopedic shoes or footwear, or support items, unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

Foot Surgery. No Benefits are available for surgical treatment of: flat feet; subluxation of the foot; weak, strained, or unstable feet; tarsalgia; metatarsalgia; or hyperkeratosis.

Free Care. No Benefits are 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.

Government Programs. No Benefits are available for Covered Services to the extent that Benefits for such services are paid or payable (or could reasonably be expected to be payable if a claim were made) under any of the following:

- Medicare or any other federal, state or local government program for which the government is the primary payer, including CHAMPUS/TRICARE. Exception: Benefits are available under this Certificate even though You may be eligible for Medicaid; or

- Any federal, state, county, municipal, or other government agency, including Medicare and the Veteran's Administration, for service-connected disabilities.

Please see Section 10, I, C for more information regarding Medicare.

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 Provider. This exclusion also applies to health spas.

Home Test Kits. No Benefits are available for laboratory test kits for home use. These include, but are not limited to, home pregnancy tests and home HIV tests.

Missed or Cancelled Appointments. 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.

Nutritional and/or Dietary Supplements. Except as specifically stated in this Certificate or as required by law, no Benefits are available for nutritional 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, IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about Benefits for some of these items.

Physical Enhancement 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.

Prescription Drugs. Except as specifically stated in this Certificate, no Benefits are available for prescription drugs purchased at a retail or mail service pharmacy, Provider's office or facility for "take home" use. **Please contact HealthTrust for prescription drug coverage information**.

Private Duty Nurses. No Benefits are available 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.

Residential Accommodations. No Benefits are available for residential accommodations that provide care for medical or behavioral health conditions, except when provided by a hospital, hospice Provider, Skilled Nursing Facility, Residential Treatment Center, or other Inpatient facility specifically covered under this Certificate. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included;

- Care provided or billed by a hotel, health resort, spa, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution;

- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included; or

- Services or care billed by a program or facility that principally or primarily provides services for individuals with medical or Mental Health or Substance Use Disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps.

Reversal of Voluntary Sterilization. No Benefits are provided for the reversal of sterilization, including Infertility treatment that is needed as a result of a prior elective or voluntary sterilization (or elective sterilization reversal) procedure. Please see Section 7, VI, C for more information on Infertility Services.

Routine Care or Elective Care Outside the Service Area. No Benefits are available for routine or elective care outside the Service Area. Routine care includes, but is not limited to, 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 or Network Provider for direction. Examples of elective care include, but are not limited to, scheduled Inpatient admissions or scheduled Outpatient care.

Smoking Cessation Drugs, Programs or Services. No Benefits are available for smoking cessation programs, products, drugs or medications, hypnosis, or supplies or devices intended to help You quit smoking, except for preventive screenings, counseling and other preventive care services for tobacco use and smoking and tobacco cessation that are covered as required by law, as stated in Section 7, II, A.

Surrogate Mother Services. No Benefits are available for services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple). Please see Section 7, VI, C for more information on Infertility Services.

Travel Costs. No Benefits are available for mileage, lodging, meals, and other Member-related travel costs except as specifically stated in this Certificate.

Vein Treatment. Except when treatment is Medically Necessary as defined in Section 14 of this Certificate, no Benefits are available for sclerotherapy for the treatment of varicose veins of the lower extremities including but not limited to, 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.

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.

SECTION 9: CLAIMS PAYMENT

Please see Section 14 for Definitions of specially capitalized words.

This Section describes how Anthem reimburses claims and what information is needed when You submit a claim. When You receive care from a Network Provider, You do not need to file a claim because the Network Provider will do this for You.

I. Maximum Allowed Amount

A. **General.** This article describes how Anthem determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this Certificate's Maximum Allowed Amount for the Covered Service that You receive. Please see "Inter-Plan Arrangements" later in this Section for additional information.

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

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

You may be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance.

Generally, services received from an Out-of-Network Provider under this Plan are not covered except for Emergency Care or Urgent Care or when approved *in advance* by Your PCP's Referral. Certain services such as inpatient admissions also require approval *in advance* by Anthem or the Local Plan's Precertification. Except for Surprise Billing Claims, when You receive Covered Services from an Out-of-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the end of this Subscriber Certificate.

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

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

B. **Provider Network Status.** The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider (as defined in Section 14) that has a written agreement, directly or indirectly, with Anthem or another Local Plan to provide Covered Services to Members. For Covered Services performed by a Network Provider, the Maximum Allowed Amount under this Certificate is the rate the Provider has agreed to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. For help in finding a Network Provider, please visit *www.healthtrustnh.org*, click on the medical icon on the homepage, then click on the applicable Provider directory button for Your Plan. Or, You may contact Anthem Member Services at the telephone number on Your identification card.

Providers who have not signed any contract with Anthem and are not in any of Anthem's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain Providers. Out-of-Network Provider is defined in Section 14. If You use an Out-of-Network Provider, Your entire claim will be denied except for Emergency Care and Urgent Care, or unless the services are approved in advance, or unless the services involve a Surprise Billing Claim.

For Covered Services You receive from an Out-of-Network Provider, except for Surprise Billing Claims, for Urgent Care or for services approved as a result of a Referral, the Maximum Allowed Amount under this Certificate will be one of the following:

- An amount based on Anthem's Out-of-Network Provider fee schedule/rate, which has been established at Anthem's discretion, and which Anthem reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with Anthem; reimbursement amounts paid by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies; and other industry cost, reimbursement and utilization data;

- An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services ("CMS") for the same services or supplies; Anthem will update such information, which is adjusted or unadjusted for geographic locality, no less than annually;

- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (i) the complexity or severity of treatment; (ii) level of skill and experience required for the treatment; or (iii) comparable Providers' fees and costs to deliver care;

- An amount negotiated by Anthem or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or

- An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Providers who are not contracted for this Plan, but are contracted for other health care plans with Anthem are also considered Out-of-Network. Under this Certificate, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown in the bullets above unless the contract between Anthem and that Provider specifies a different amount or if Your claim involves a Surprise Billing Claim.

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

Unlike Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount unless Your claim involves a Surprise Billing Claim. You may be responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. For help in finding a Network Provider, please visit *www.healthtrustnh.org,* click on the medical icon on the homepage, then click on the applicable Provider directory button for Your Plan. Or, You may contact Anthem Member Services at the number on Your identification card.

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

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

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

Referrals. In some circumstances, such as where there is no Network Provider available for the Covered Service, Anthem may authorize the Network cost share amounts (Deductible, Copayment or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstances, You or Your Network Provider must contact Anthem in advance of obtaining the Covered Service. Please see Section 4 for further information on Referral requirements. Anthem may also authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency Care or Urgent Care from an Out-of-Network Provider and are not able to contact Anthem until after the Covered Service is rendered. If Anthem authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless Your claim is a Surprise Billing Claim. For additional information or to request authorization for a Referral, please contact Anthem's Member Services at the telephone number on Your identification card.

II. Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking Emergency Care, Urgent Care or other services authorized according to the terms of this Plan from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

A. **Post-Service Claims.** A Post-Service Claim is any claim for a Benefit for which the terms of the Plan do not condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining the medical care. "Post-Service Claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and Anthem.

1. **Notice of Claim and Proof of Loss.** After You get Covered Services, Anthem must receive written notice of Your claim in order for Benefits to be paid.

a. Network Providers will submit claims for You. They are responsible for ensuring that claims have the information that Anthem needs to determine Benefits. If the claim does not include enough information, Anthem will ask them for more details, and they will be required to supply those details within certain timeframes.

b. Out-of-Network Provider claims can be submitted by the Provider if the Provider is willing to file on Your behalf. However, if the Out-of-Network Provider is not submitting on Your behalf, You will be required to submit the claim. If the Provider does not have a claim form, please contact HealthTrust or Anthem to obtain the correct claim form as prescribed by Anthem for submission. Anthem Member Services' telephone number is on Your identification card. 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.

If You are not able to contact HealthTrust or Anthem, or if HealthTrust or Anthem fails to furnish a claim form to You, written notice of the claim may be submitted to Anthem without the claim form. The time limit for submission will be met if You submit a written claim for Benefits within the time limit stated in this article. Your written claim for Benefits must include the same information that would be given on Anthem's prescribed claim form. This includes:

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

c. Time Limit for Submitting Out-of-Network Provider Post-Service Claims. In order for Anthem to make payments for Out-of-Network 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; or
- An extension of the filing period is required by applicable law.

If the claim does not include enough information, Anthem will ask You for more details and inform You of the time by which Anthem needs to receive that information. Once Anthem receives the required information, Anthem will process the claim according to the terms of Your Plan. **Please note that failure to submit the information Anthem needs by the time listed in their request could result in the denial of Your claim, unless applicable law requires an extension.** Please contact Member Services if You have any questions or concerns about how to submit claims.

d. Legal Action. No action may be brought to recover Benefits for any service covered under this Certificate unless the required notice or proof of claim has been given to Anthem within the time frame required under this Certificate and such action is commenced no earlier than 60 days and no later than 3 years following the date that the notice or proof of claim has or should have been provided to Anthem.

2. 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.

B. Pre-Service Claims. A Pre-Service Claim is any claim for a Benefit under the Plan with respect to which the terms of the Plan condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining the medical care. "Pre-Service Claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and Anthem.

1. 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 Provider with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the proposed care or treatment.

2. **Timeframes for Making Pre-Service Claim Determinations.** Anthem will make a determination about Your Pre-Service Claim within the following timeframes. Timeframes begin when Your claim is received and end when a determination is made.

- **For Non-Urgent Care 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 urgencies of Your medical condition, 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 Anthem Member Services at the number on Your identification card. Exception: for Urgent Care Claims, Anthem will consider a health care professional with knowledge of Your condition (such as Your treating Provider) to be Your authorized representative without requiring Your written acknowledgment of the representation.

III. Notice of an Adverse Benefit Determination

Adverse Benefit Determination 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 an individual's eligibility for coverage under this Certificate. Adverse Benefit Determination 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, as well as rescission of coverage.

Anthem's notice of a Post-Service or a Pre-Service Adverse Benefit Determination will be in writing or by electronic means and will include the following:

- The specific reason(s) for the determination, including the specific provision of Your Plan on which the determination is based;

- 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 Adverse Benefit Determination or when the Adverse Benefit Determination 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;

- If the Adverse Benefit Determination is based upon a determination that the claim is Experimental or Investigational or not Medically Necessary or appropriate, the notice will include:

    - 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 Adverse Benefit Determination is not the Medical Director but a designee, the designee's credentials, board status, and state(s) of current license will be included, and

    - 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;

- If an internal guideline (such as a rule, protocol, or other similar provision) was relied upon in making the Adverse Benefit Determination, 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; and

- If clinical review criteria were relied upon in making any Adverse Benefit Determination, the notice will include a statement that such criteria were relied upon. The explanation of any clinical rationale provided 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.

You may appeal any Adverse Benefit Determination. Please see Section 11 for information about how to use the appeal procedure.

IV. Member's Cooperation

You will be expected to complete and submit to Anthem all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If You fail to cooperate, You will be responsible for any charge for services. Please see Section 10, V, "Your Agreement and Responsibility Under This Certificate" for more information.

V. Payment of Benefits

Anthem will make payments directly to Network Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. We reserve the right to make payments directly to You as opposed to any Provider for Covered Services, at our discretion, except for claims for Emergency Care or Surprise Billing Claims for air ambulance services or non-Emergency services performed by Out-of-Network Providers at certain In-Network facilities, which will be paid directly to Providers and facilities. In the event that payment is made directly to You, You have the responsibility to apply the payment to the claim from the Out-of-Network Provider. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Medical Child Support Order, as having a right to enrollment under the Group's Plan), or that person's custodial parent or designated representative. Any payments made by Anthem will discharge the Plan's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a Medical Child Support Order. Once a Provider performs a Covered Service, Anthem will not honor a request to withhold payment of the claims submitted.

VI. Inter-Plan Arrangements – Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You obtain healthcare services outside of the Plan's Service Area, the claims for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Plan's Service Area, You will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("non-participating providers") don't contract with the Host Blue. The Plan's payment practices for both kinds of Providers are described below.

The Plan covers only limited healthcare services received outside of the Plan's Service Area ("Out-of-Area Covered Services"). For example, Emergency Care or Urgent Care obtained outside the Anthem Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem. These "other services" must be authorized by Your Primary Care Provider ("PCP").

A. **BlueCard® Program.** Under the BlueCard® Program, when You receive Out-of-Area Covered Services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for: (i) contracting with its Providers; and (ii) handling all interactions with those Providers.

The BlueCard Program enables You to receive Out-of-Area Covered Services from a participating provider, where available. The participating provider will automatically file a claim for the Out-of-Area Covered Services provided to You, so there are no claim forms for You to fill out. You will be responsible for any applicable cost sharing amounts, as shown on Your Cost Sharing Schedule.

When You receive Out-of-Area Covered Services and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Occasionally, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Anthem used for Your claim because they will not be applied after a claim has already been paid.

B. **Special Cases: Value-Based Programs Under BlueCard® Program.** If You receive Out-of-Area Covered Services under a Value-Based Program inside a Host Blue's Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

C. **Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees.** Federal or state laws or regulations may require the Host Blue to add a surcharge, tax or other fee. If applicable, Anthem will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

D. Non-Participating Providers Outside the Plan's Service Area

1. **Allowed Amounts and Member Liability Calculation.** When Out-of-Area Covered Services are provided by non-participating providers, Anthem may determine Benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, unless Your claim is a Surprise Billing Claim, You may be responsible for the difference between the amount that the non-participating provider bills and the payment Anthem will make for the Out-of-Area Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network Emergency Care services.

2. **Exceptions.** In certain situations, Anthem may use other pricing methods, such as billed charges or the pricing Anthem would use if the healthcare services had been obtained within the Plan's Service Area, or a special negotiated price to determine the amount the Anthem will pay for services provided by non-participating providers. In these situations, You may be liable for the difference between the amount that the non-participating provider bills and the payment Anthem makes for the Out-of-Area Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core. If You plan to travel outside the United States, call Anthem Member Services to find out Your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency Care, including ambulance, and Urgent Care outside of the United States. Remember to take an up-to-date medical identification card with You.

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven days a week. The number is 1-800-810-BLUE (2583).

If You need Inpatient hospital care, You or someone on Your behalf should contact Anthem for Precertification. Keep in mind, if You need Emergency Care, go to the nearest hospital. There is no need to call before You receive care. Please refer to Section 4 for further information about how to get Precertification when You need to be admitted to the hospital for Emergency Care or non-emergency care.

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

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

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

You will need to file a claim form for any payments made up front. When You need **Blue Cross Blue Shield Global Core** claim forms You can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or
- Online at *www.bcbsglobalcore.com*. You will find the address for mailing the claim on the form.

SECTION 10: OTHER PARTY LIABILITY

Please see Section 14 for Definitions of specially capitalized words.

The following Coordination of Benefits (COB) guidelines and related other party liability rules apply to all claims that are submitted for payment under the Plan.

I. Coordination of Benefits (COB)

Coordination of Benefits 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 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 other 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.

- The medical benefits coverage in automobile "no fault" or "personal injury protections" (PIP) type contracts, not including medical payments coverage, also known as part B in the personal automobile policy or med pay.

For 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; Medicaid policies; or coverage under other federal 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 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.

- The medical benefits coverage in automobile "no fault" or "personal injury protection" (PIP) type contracts, not including medical payments coverage, also known as Part B in the personal automobile policy or med pay.

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

Please remember that Your cost sharing amounts under this Certificate (such as Copayments, Deductibles and Coinsurance, and amounts that exceed the Maximum Allowed Amount or any annual limits) are Your responsibility whether this Plan is Primary or Secondary. A copay doesn't apply on secondary claim(s) if already applied on the primary claim(s). Also, other rules stated throughout this Certificate (such as any applicable Provider network or Referral rules) apply whether this Plan is Primary or Secondary.

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.

A. 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 Plan is Primary, this Plan will provide the full extent of Benefits covered under this Certificate, up to the Maximum Allowed Amount 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 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 Plan. Allowable Expenses include, but are not limited to, 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:

    i. 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.

    ii. 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.

    iii. 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 plan 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 this Plan 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 the Maximum Allowed Amount.

- 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 or other similar reimbursement methodologies and does not negotiate fees with Providers, the combination of

benefits paid by the Primary plan and this Plan will not exceed the Maximum Allowed Amount.

The difference between the Maximum Allowed Amount 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, but are not limited to: 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.

B. 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.

1. Important General Rules:

- **Services Outside the United States of America (U.S.A.).** 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).

- **Liability Laws.** To the extent permitted by applicable law, when any benefits are available as Primary benefits to a Member under Medicare (see article C, "Medicare Program" below) or any Workers' Compensation Laws, Occupational Disease Laws or other employer liability laws, those benefits will be Primary.

- **No or Inconsistent COB Rule.** 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.

2. Order of Payment Rules. If You are covered by more than one health care plan or policy and none of the "Important General Rules" listed above apply, the order of benefits will be determined by using the first of the following rules that apply:

- **Employee/Dependent Rule.** 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:

  i. 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.

  ii. 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 the court decree terms, that plan is Primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

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 the "birthday rule" (above) 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 the "birthday rule" (above) 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:

- The plan covering the custodial parent;
- The plan covering the spouse of the custodial parent;
- The plan covering the non-custodial parent; and then
- The plan covering the spouse of the non-custodial parent.

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 calendar 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 (i) or (ii) 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 "Employee/Dependent Rule" above can determine the order of benefits.

- **COBRA or Other Continuation Coverage.** If a Member is covered under COBRA or a similar "right of continuation" law under either federal law or other continuation coverage, 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 "Employee/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 shorter 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.

C. **Medicare Program.** Medicare Secondary Payer (MSP) laws determine whether Medicare benefits will be Primary or Secondary to the Benefits available under this Plan. Factors that determine which plan is Primary include, but are not limited to, 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 Plan is Primary. If Medicare is the Primary plan according to MSP laws, this Plan is Secondary. When Medicare is the Primary plan, You need to be enrolled in Parts A and B of Medicare because Benefits under this Plan will only be paid Secondary to Benefits available under Parts A and B of Medicare. The Secondary Benefits payable under this Plan will assume that You are eligible to receive both Medicare Part A and Part B benefits.

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 Medical Enrollment Application. If You become entitled to Medicare benefits after You enroll, You must inform Your Group Benefits Administrator and HealthTrust immediately.

When You become entitled to Medicare benefits, You should contact Your local Social Security Office right away to discuss Medicare rules regarding enrollment in both Parts A and B of Medicare.

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certficate terms, and federal law.

Except when federal law requires the Plan to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled to or enrolled in under Medicare, including Parts A and/or B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to You shall be reimbursed by or on Your behalf to the Plan, to the extent the Plan has made payment for such services. If You do not enroll in Medicare Parts A and/or B when You are eligible, and Medicare would be primary, the Plan will calculate benefits as if You had enrolled. You may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when You should enroll, and when You are allowed to delay enrollment without penalties.

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 this Plan pays Benefits as a result of an injury, illness, impairment or medical condition You sustain and You have a right to a Recovery or have received a Recovery. For purposes of this Certificate, "Recovery" shall mean money You receive or are entitled to receive from another person, entity or any other source as a result of injury, illness, impairment or medical condition caused by another. Such payments shall include but are not limited to, any money from another, the other's insurer or from any "Home Owner's," "Uninsured Motorist," "Underinsured Motorist," "No-Fault," "Personal Injury Protection" or other insurance coverage or similar provision. These provisions do not apply to medical payments coverage, also known as Part B in a personal automobile policy or med pay. 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. HealthTrust and/or Anthem must be reimbursed by the Member for such payments from medical payments coverage and other property and casualty insurance including, but not limited to automobile and 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 but not limited to, automobile and 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.

A. **Subrogation.** If You suffer an injury, illness, impairment or medical condition that is the result of another party's actions, and this Plan pays Benefits to treat such injury, illness, impairment or medical condition, HealthTrust will be subrogated to Your Recovery rights. HealthTrust, and/or Anthem acting on HealthTrust's behalf, may proceed in Your name against the responsible party. Additionally, HealthTrust and/or Anthem acting on HealthTrust's behalf shall have the right to recover payments this Plan makes 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:

- HealthTrust and/or Anthem acting on HealthTrust's behalf may pursue HealthTrust's subrogation rights and shall have first priority for the full amount of Benefits this Plan 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 may not waive or otherwise prejudice in any way HealthTrust's subrogation rights set forth in this Section. You and Your legal representative must do whatever is necessary to enable HealthTrust and/or Anthem to exercise such rights.

- HealthTrust and/or Anthem have the right to take whatever legal action they see 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 HealthTrust's and/or Anthem's subrogation claim and any claim still held by You, HealthTrust's and/or 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.

- This Plan, HealthTrust and Anthem are not responsible for any attorney fees, other expenses or costs You incur without the prior written consent of HealthTrust. Further, the "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay Benefits paid by this Plan.

Nothing in this Section shall be construed to limit the Plan's, HealthTrust's and/or Anthem's right to utilize any remedy provided by law to enforce HealthTrust's rights to subrogation under this Section. HealthTrust, and/or Anthem acting on its behalf, is entitled to reimbursement from the responsible party or any other party You receive payment from to the extent of Benefits provided. HealthTrust and/or Anthem reserves the right to compromise on the amount of the claim if HealthTrust and/or Anthem acting on its behalf determines that it is appropriate to do so. Any action that interferes with HealthTrust's subrogation rights may result in the termination of coverage for the Subscriber and covered Dependents.

B. **Reimbursement.** If You obtain a Recovery and HealthTrust and/or Anthem have not been repaid for the Benefits this Plan paid on Your behalf, HealthTrust and/or 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:

- HealthTrust and/or Anthem are entitled to reimbursement from any Recovery, in first priority, 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 HealthTrust and/or 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 HealthTrust and/or Anthem immediately upon Your receipt of the Recovery. You must fully reimburse HealthTrust and/or Anthem, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to

any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay Benefits paid by this Plan.

- This Plan shall be entitled to deduct any of the unsatisfied portion of the amount of Benefits paid by the Plan or the amount of Your Recovery, whichever is less, from any future Benefits under the Plan if:

  i. You fail to disclose to HealthTrust and/or Anthem the amount of Your Recovery;
  ii. The amount this Plan paid on Your behalf is not repaid or otherwise recovered by HealthTrust and/or Anthem; or
  iii. You fail to cooperate with HealthTrust and/or Anthem.

- HealthTrust and/or Anthem shall also be entitled to recover any of the unsatisfied portion of the amount paid by the Plan 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 the Plan would have no obligation to pay the Provider.

IV. HealthTrust's and Anthem's Rights Under this Certificate

A. **General.** HealthTrust, and/or Anthem acting on HealthTrust's behalf, reserves the right to:

- Take any action needed to carry out the terms of this Section and the Certificate,
- Exchange information with other insurance companies and/or other parties,
- Recover any excess payment made under this Plan from another party or reimburse another party for its excess payment, and
- Take the actions set forth in this Section when 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 the dissemination of information prohibited by law.

Whenever another plan or entity pays benefits that should have been paid by this Plan, Anthem, on behalf of the Plan, has the right to pay the other plan or entity any amount that Anthem determines in its discretion 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, the Plan, HealthTrust and Anthem are fully discharged from liability under this Certificate.

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

B. **Mistaken Payments and Right of Recovery.** On occasion, a payment may be made by the Plan to You or on Your behalf in error (for example, when You are not covered, for a service which is not covered, or which is more than is appropriate for the service). Whenever a payment has been made in error, HealthTrust and/or Anthem acting on HealthTrust's behalf, has the right to recover such payment from You or any Member, Provider, or other person or entity to whom or for whom such payment was made. The right of recovery may result in an adjustment to the claim. Anthem is given the right to deduct or offset any amounts paid in error by the Plan from any pending or future claim. Anthem has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses, and when to settle or compromise recovery or adjustment amounts. In most instances, recovery or adjustment activity will occur within 12 months of the date of a payment made. Recovery or adjustment can occur beyond 12 months in certain circumstances when, for example, the claim payment was made incorrectly, the healthcare was not delivered by the Provider, or the claim was submitted fraudulently. The Plan will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

V. Your Agreement and Responsibility Under This Certificate

You have the responsibility to provide prompt, accurate and complete information to HealthTrust and Anthem about other health care plans and/or insurance policies or benefits You may have in addition to Your HealthTrust coverage. Other health care plans, insurance policies or benefits include, but are not limited to, benefits from other health coverage, Workers' 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 HealthTrust and 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 agree to:

- Promptly notify HealthTrust and/or 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 HealthTrust and/or Anthem in the investigation, settlement and protection of rights,
- Not do anything to prejudice the rights of HealthTrust and Anthem,
- Send to HealthTrust and/or 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
- Promptly notify HealthTrust and/or Anthem if You retain an attorney or if a lawsuit is filed on Your behalf, if a settlement occurs, or if potentially dispositive motions are filed in a case.

Any action which interferes with HealthTrust's rights under this Section or the Certificate may result in the termination of coverage for the Subscriber and covered Dependents.

Please call Anthem Member Services at the number on Your identification card if You have questions about any portion of this Section.

SECTION 11: MEMBER SATISFACTION SERVICES, INTERNAL APPEAL PROCEDURE AND EXTERNAL REVIEW

Please see Section 14 for Definitions of specially capitalized words.

This Section explains how to contact HealthTrust and Anthem when You have questions, suggestions, concerns or complaints. Please note that oral statements by agents or representatives of HealthTrust or Anthem do not change the Benefits described in this Certificate.

I. Member Satisfaction Services

HealthTrust and Anthem provide quality Member satisfaction services through their respective Enrollee Services and Member Services. All HealthTrust and Anthem personnel are responsible for addressing Your concerns in a manner that is accurate, courteous, respectful and prompt. 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 Plan materials that You want or need,
- Make sure Your suggestions are brought to the attention of the appropriate persons at HealthTrust or Anthem, and
- Provide assistance to You (or Your authorized representative) when You want to file an internal appeal.

HealthTrust and Anthem use Your identification number 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.

We want Your experience with us to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. HealthTrust or Anthem will try to resolve Your inquiry informally. If You are not satisfied with the response provided, You have the right to file an appeal. Please see articles II and III of this Section for more information about appeals procedures.

If You have a concern about the quality of care offered to You by a Network Provider (such as waiting times, Provider behavior or demeanor, adequacy of facilities or other similar concerns), You are encouraged to discuss Your concerns directly with the Provider before You contact an Anthem Member Services Representative.

Please contact **HealthTrust** about Your enrollment, wellness programs, or Plan materials. Call HealthTrust Enrollee Services at: **1-800-527-5001.** Or, You may write to:

HealthTrust
PO Box 617
Concord, NH 03302-0617

Please contact **Anthem Member Services** about Your Benefits, Covered Services, Plan materials, or Network Providers. Call Anthem at the telephone number on Your identification card**.** Or, You may write to:

Member Services
Anthem Blue Cross and Blue Shield
PO Box 660
North Haven, CT 06473-0660

II. Internal Appeal Procedure

You have the right to receive Benefits as described in this Certificate. You may appeal any Adverse Benefit Determination made by Anthem. This Section explains the Internal Appeal procedure. **You or Your authorized representative must file Your appeal within 180 days after You are notified of the Adverse Benefit Determination.** Please see Section 9, III, "Notice of an Adverse Benefit Determination."

By accepting this Certificate, You agree that You will take no court action related to Your coverage or Benefits under the Plan before completing the steps described below. Your obligations under this Certificate are fulfilled when the first level internal appeal procedure is completed as stated in this article. A voluntary second level of internal appeal, which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal, is also available as stated in this article. The time frame allowed for Anthem to complete its review is dependent upon the type of review involved (e.g., pre-service, urgent, concurrent, post-service, etc.).

Please see Section 14 for definitions of "Adverse Benefit Determination," "Urgent Care Claim," "Pre-Service Claim" and "Post-Service Claim."

Internal appeals are conducted and overseen by Anthem. No fees for submitting an appeal will be assessed against You or Your authorized representative.

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 Anthem Member Services at the telephone number on Your identification card. Exception: For Urgent Care Claim appeals, Anthem will consider a health care professional with knowledge of Your condition (such as Your treating Provider) 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? You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. Anthem's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination. 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;

- Any information that You believe is important for review, such as statements from Your Provider or letters You received from Anthem; and

- A reference to 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.

A. First Level Appeal. To exercise Your right to a first level internal appeal, please take the following steps:

Expedited Appeals. For Pre-Service Claims involving an Urgent Care Claim or concurrent care claim denial, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and You by telephone, facsimile or other similar method.

To file an appeal of an Urgent Care Claim or concurrent care claim denial, You or Your authorized representative must contact Anthem at the number shown on Your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

Non-Expedited Appeals. All other requests for appeals should be submitted in writing, unless Anthem determines that it is not reasonable to require a written statement. You or Your authorized representative must submit a request for review to:

Appeals Department
Anthem Blue Cross and Blue Shield
P.O. Box 518
North Haven, CT 06473-0518

Upon request, Anthem will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

Anthem will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an Adverse Benefit Determination or review based on a new or additional rationale, Anthem will provide You, free of charge, with the rationale.

How Your Appeal will be Decided. When Anthem considers Your appeal, Anthem will not rely upon the initial benefit determination or, for voluntary second level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second level review will be conducted by an appropriate reviewer who did not make the initial determination or the first level appeal determination and who does not work for the person who made the initial determination or first level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Timeframes for First Level Appeal Determinations. Anthem will notify You of the outcome of Your appeal in the following timeframes:

- **For an appeal of a Pre-Service Claim involving an Urgent Care Claim or concurrent care claim (Expedited Appeal)**, Anthem will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

- **For an appeal of any other Pre-Service Claim**, Anthem will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

- **For an appeal of a Post-Service Claim**, Anthem will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

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 denial notice will be considered an Adverse Benefit Determination and will include the following:

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

- If an internal rule, guideline, protocol or other similar provision was relied upon in making the Adverse Benefit Determination, a statement that such a rule, guideline, protocol or other similar provision was relied upon; and

- 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;

    - 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;

    - 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 Adverse Benefit Determination is based) relevant to Your claim for Benefits. The records on file with Anthem may be limited in scope. Please contact Your Provider 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 a second level internal appeal, External Review or for bringing a legal action.

B. **Voluntary Second Level Appeal.** If You are not satisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. You are not required to complete a voluntary second level appeal prior to submitting a request for independent External Review. If You would like to initiate a second level appeal, please submit Your request to Anthem at:

Appeals Department
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518

Your appeal must be in writing unless Anthem determines that it is not reasonable to require a written statement. For example, expedited appeals may be submitted orally or in writing. **Your appeal must be submitted within at least 180 days of Anthem's notice stating the results of Your first level internal appeal.** You do not have to re-send the information that You submitted for Your first level internal appeal. However, You are encouraged to submit any additional information that You think is important for review. If Anthem finds that more information is required in order to conduct Your appeal, You will be notified in writing as soon as possible.

A voluntary second level review will be conducted by an appropriate reviewer who did not make the initial determination or the first level appeal determination and who does not work for the person who made the initial determination or first level appeal determination.

Timeframes for Voluntary Second Level Appeal Determinations. Anthem will complete a voluntary second level appeal within 45 business days after receiving all the information necessary to complete the review.

III. External Review

If the outcome of the mandatory first level internal appeal and/or voluntary second level internal appeal is based on medical judgment and adverse to You, You may be eligible for an independent External Review pursuant to federal law. There is no charge for You to initiate an independent External Review. This is not an additional step that You must take in order to fulfill Your appeal procedure obligations described above. Your decision to seek External Review will not affect Your rights to any other Benefits under this Plan. The External Review decision is final and binding on all parties except that it does not prevent You from pursuing any other remedy You may have under this Plan or at law.

You must submit Your request for External Review to Anthem **within four (4) months** of the notice of Your final internal Adverse Benefit Determination. A request for an External Review must be in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that You submitted for internal appeal(s). However, You are encouraged to submit any additional information that You think is important for review.

Expedited External Review. For Pre-Service Claims involving Urgent Care Claim or concurrent care claim denials, You may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through Anthem's internal appeal process. You or Your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and You by telephone, facsimile or other similar method.

To proceed with an Expedited External Review, You or Your authorized representative must contact Anthem at the number shown on Your identification card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

Non-Expedited External Review. All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Appeals Department
Anthem Blue Cross and Blue Shield
P.O. Box 518
North Haven, CT 06473-0518

HealthTrust and Anthem reserve the right to modify the policies, procedures and timeframes in this Section upon further clarification from the Department of Health and Human Services or the Department of Labor.

IV. Requirements Before Filing a Lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for Benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's Internal Appeal Procedure (but not including any voluntary second level of appeal) before filing a lawsuit or taking other legal action related to Your coverage or Benefits under the Plan.

V. Disagreement With Recommended Treatment

Your Provider is responsible for determining the health care services that are appropriate for You. You may disagree with Your Provider's decisions and You may decide not to comply with the treatment that is recommended by Your Provider. You may also request services that Your Provider 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 Provider. In all cases, Anthem, on behalf of HealthTrust, 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 for Definitions of specially capitalized words.

I. Amendment and Termination

HealthTrust may amend or modify the Plan or this Certificate through a written amendment approved by a duly authorized representative of HealthTrust. Upon the approval of any such amendment, it will become effective in accordance with its terms as to You and all other Members. No person or entity has any authority to make any oral changes or oral amendments to the Plan or this Certificate. HealthTrust reserves the right to terminate the Plan by giving advance notice of at least 30 days to You and Your Group.

II. Applicable Law

The Plan and this Certificate shall be construed and enforced according to the applicable laws of the State of New Hampshire, except as the same may be superseded by applicable federal law.

III. Waiver of Rights

On occasion, HealthTrust may, at its option, choose not to enforce all the terms and conditions of this Certificate; however, HealthTrust does not thereby waive or give up any rights to enforce any term or condition in the future. No agent of HealthTrust or Anthem has the right to change or waive any of the provisions of this Certificate without the approval of an authorized representative of HealthTrust.

IV. HealthTrust and Anthem are not Responsible for Acts of Providers

HealthTrust and Anthem are not liable for the acts or omissions of any individuals or institutions furnishing care or services to You.

V. Rights to Administer Plan

HealthTrust reserves the right to determine eligibility for participation in this Plan. Anthem, as delegated by HealthTrust, or anyone acting on Anthem's behalf, shall determine the administration of Benefits in such a manner that has a rational relationship to the terms set forth herein. Anthem's determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental or Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowed Amount. However, a Member may utilize all applicable appeals procedures.

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

VI. Limitation on Enforcement of This Certificate

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

VII. Confidentiality and Privacy

HealthTrust and Anthem undertake efforts to safeguard the privacy and confidentiality of Your personal health information in accordance with applicable state and federal laws regarding privacy of personal and health information. HealthTrust's Notice of Privacy Practices, which describes HealthTrust's privacy practices, is available on HealthTrust's website at *www.healthtrustnh.org*. To request a copy of the Notice, or if You have questions about the privacy of Your personal and health information, please contact HealthTrust as follows:

Privacy Officer
HealthTrust, Inc.
PO Box 617
Concord, NH 03302-0617
800-527-5001 or 603-226-2861 (Local)
privacyofficer@healthtrustnh.org

VIII. Acknowledgment of Understanding

It is expressly acknowledged and understood that the administrative services provided by Anthem for You, Your Group and HealthTrust are subject to an agreement between Anthem and HealthTrust, and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of New Hampshire. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C., and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This provision shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under the provisions of this Certificate and the agreement between Anthem and HealthTrust.

IX. Right of Offset

HealthTrust reserves the right to empower Anthem to offset any amounts owed to the Plan by a Member against any amounts due from the Plan to such Member or any other Member receiving Benefits through the same Subscriber.

X. Separability Clause

If any provision of this Certificate is invalid or unenforceable under any applicable statute or rule of law, then the affected provision shall be curtailed and limited only to the extent necessary to bring the provision within the applicable legal requirements and this Certificate as so modified shall continue in full force and effect.

XI. Spendthrift Provision

The right to receive Benefits under the 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 for the payment of any applications of the Member.

XII. Non-ERISA Governmental Plan

The Plan is a governmental plan established and maintained by HealthTrust and Your Group, and as such is exempt from the provisions of the Employee Retirement and Income Security Act of 1974, as amended (ERISA).

XIII. Headings, Pronouns and Cross References

Section and article 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, when You review Section 7, "Covered Services," please also 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.

XIV. Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, we will make a good-faith effort to ensure Covered Services are available to you. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster, epidemic, war, when health care services covered under this Plan are delayed or rendered impractical, or other events beyond our control. Under such circumstances, we will not be responsible for any delay or failure to give services due to lack of available facilities or staff.

SECTION 13: ELIGIBILITY, ENROLLMENT, TERMINATION OF COVERAGE AND CONTINUATION OF COVERAGE

Please see Section 14 for Definitions of specially capitalized words.

I. Eligibility

You must meet Your Group's and HealthTrust's eligibility rules and the terms set forth in this Certificate to be eligible to enroll in the Plan. Please contact Your Group for information about Your Group's specific eligibility rules.

No person who is eligible to enroll will be denied enrollment based on health status, current or past medical conditions (physical or mental), claims experience or receipt of health care services, genetic information, disability, sexual orientation or gender identity, gender, or evidence of insurability (including conditions arising out of domestic violence).

A. **Subscriber.** If You meet the definition of Employee as defined in Section 14, You are eligible to enroll as a Subscriber on the first day of the calendar month following the date determined mutually by Your Group and HealthTrust in accordance with applicable rules and procedures of HealthTrust, provided that You:

1. Are certified as being an eligible Employee or Retiree by Your Group; and
2. Have satisfied any applicable Probationary Period established by Your Group.

If You are eligible to enroll as a Subscriber You may enroll in "single" (Subscriber only) coverage. You may also enroll in "two person" or "family" coverage, if offered by Your Group and all applicable eligibility requirements are met.

B. **Dependents.** Depending upon the type of coverage You select ("two person" or "family"), in addition to You, the Subscriber, the following members of Your family are also eligible for enrollment under the Plan as Dependents, provided that coverage for such family members is offered by Your Group. To be eligible to be enrolled as a Dependent, the family member must be listed on the Medical Enrollment Application completed by the Subscriber, meet all Dependent eligibility criteria established by Your Group and HealthTrust, and be one of the following:

- **Your Spouse.** For information on spousal eligibility, please contact Your Group. If Your Group offers spousal coverage, Your spouse is eligible to enroll unless You are legally separated. Throughout this Certificate, any reference to "spouse" means:
  - The individual to whom You are lawfully married, as recognized under state or federal law.
  - The individual with whom You have 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.

  Coverage is available for same-sex or opposite-sex Domestic Partners (including "common law" type relationships and other unmarried couples) **only if** Your Group has elected a Domestic Partner Rider with this Certificate and **only if** all of the criteria for membership are met, as stated in the Domestic Partner Rider.

- **Your or Your Spouse's Dependent Children Under 26 Years of Age.** "Children" include: natural children, stepchildren, legally adopted children, children for whom You are the proposed adoptive parent and who have been lawfully placed in Your custody pursuant to an adoption proceeding under the provisions of New Hampshire law before the adoption becomes final, children for whom You are the legal guardian including children for whom You were the legal guardian at the time the child attained 18 years of age **and** the legal guardianship terminated by operation of NH RSA 463:15(I), and children for whom there is a Medical Child Support Order in effect, or as otherwise required by law. Foster children and grandchildren are not eligible for coverage unless they meet the definition

of "children" above. Please see "Special Enrollment," "Newborn Children" and "Adopted Children" in article II of this Section for more information.

Enrolled eligible Dependent children will continue to be covered until the end of the month in which the child attains age 26. Coverage may be continued past the age limit for an Unmarried Incapacitated Dependent child as described in the following paragraph.

- **Your or Your Spouse's Unmarried Incapacitated Dependent Child.** An unmarried child 26 years of age or older and incapable of self-support due to physical or mental handicap (as certified by a Provider), when coverage would otherwise end because the child no longer meets any of the eligibility criteria outlined above. The physical or mental incapacity must have occurred *before* the child reached age 26 and must have occurred while the Dependent was a covered Dependent child. 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. HealthTrust must receive an application for the incapacitated Dependent child status and medical certification of the incapacity by a Provider within 31 days of the date coverage would otherwise end for the child. Anthem must certify Your Dependent child's incapacitated status and HealthTrust will periodically request that the incapacitated status of Your child be recertified.

C. **Accuracy and Verification of Enrollment Information.** By accepting this Certificate, You represent that all statements made in Your Medical Enrollment Application, or any other documentation You provide with respect to eligibility and enrollment of You or Your Dependents, are true to the best of Your knowledge and belief. You agree to give HealthTrust information upon request that HealthTrust needs to verify coverage eligibility. Examples of documentation that HealthTrust may need to decide membership eligibility are information regarding: Dependent child status, incapacitated Dependent child status, marital status, divorce, legal separation, birth, adoption or court orders regarding health care coverage for Your Dependent children. HealthTrust reserves the right to deny enrollment or cancel Your and/or Your Dependents coverage under the Plan to the extent permitted by law if You fail to provide verification upon request or misrepresent the eligibility status of You or any of Your Dependents.

Rescission. HealthTrust may terminate a Member's coverage back to the original effective date for any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact on the part of a Member.

II. Enrollment and Effective Date of Coverage

A. **Initial Enrollment.** If You have satisfied the eligibility requirements described in article I of this Section, You may enroll Yourself and any then eligible Dependents by submitting a Medical Enrollment Application to Your Group Benefits Administrator within 31 days from the date You first satisfy such requirements, including any applicable Probationary Period (as described in the following paragraph). Provided HealthTrust receives the Application within 31 days of Your satisfying the eligibility requirements, coverage will become effective as of the first day of the month following Your eligibility date. An applicant is considered enrolled only upon acceptance of the Medical Enrollment Application by HealthTrust. If a Medical Enrollment Application is received by HealthTrust after 31 days, but within 60 days, from the date You first satisfy Your Probationary Period, Your coverage and the coverage of any eligible Dependents then being enrolled will become effective on the first day of the month following receipt of the Application. If Your Medical Enrollment Application is not submitted within the required timeframes when You first become eligible, You (and/or Your eligible Dependents) may not enroll at a later date, except during an open enrollment period, a special enrollment period, or in the case of "Qualified Family Status Changes" (as described later in this Section).

Your Group may impose an initial enrollment Probationary Period for new Subscribers and their Dependents when the Subscriber is first eligible for coverage. A Probationary Period is a period of time, if any, established by Your Group that You must work before You are eligible to enroll for coverage under this Plan. Coverage will become effective based on the Probationary Period chosen by Your Group, but in no event will coverage become effective later than 90 days from the date You first satisfy the eligibility requirements (other than any applicable Probationary Period) described in article I of this Section.

If You return from full-time active service following a call to active military duty, no Probationary Period applies. You and eligible family members can reenroll in Your Group's Plan as permitted by law, and 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 Plan, Your application must be received within 31 days of Your reemployment date. Coverage will be effective on the effective date of Your reemployment.

B. **Open Enrollment.** There will be an annual open enrollment period as determined by Your Group during which You may apply for or change coverage for You and/or Your eligible Dependents. Open enrollment is generally a period of 30 to 60 days prior to Your Group's Anniversary Date (either January 1 or July 1) each year, and also may include the month of Your Group's Anniversary Date. If a Medical Enrollment Application is received by HealthTrust on or before the last day of the month of Your Group's Anniversary Date, coverage will be effective as of either the Anniversary Date or the first of the month following receipt of the Application, as determined by Your Group. If, however, the Medical Enrollment Application is not received by HealthTrust by the end of the month of Your Group's Anniversary Date, the requested enrollment may not be made until the next open enrollment, a special enrollment period, or in the case of a qualified family status change (as described later in this article II). Special open enrollment periods may be allowed for a Group at the sole discretion of HealthTrust.

C. **Special Enrollment.** If You and/or Your eligible Dependent(s) do not enroll when first eligible, You may be able to enroll prior to the next open enrollment if You qualify for special enrollment. A special enrollment period will be available to You and/or Your eligible Dependents in the following circumstances in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) and the Children's Health Insurance Program Reauthorization Act of 2009:

- **Involuntary Loss of Other Insurance Coverage.** If You decline enrollment for Yourself or Your Dependents because of other health insurance coverage, You may in the future be able to enroll those individuals in this Plan other than at Your Group's open enrollment period, provided that You request enrollment and apply within 31 days after an involuntary loss of such other insurance coverage. For this purpose, an involuntary loss of other insurance coverage means (i) if the other coverage is COBRA continuation coverage, such COBRA coverage has been exhausted, or (ii) if the other coverage is not COBRA coverage, the coverage is ended due to a loss of eligibility for that coverage (other than for nonpayment of employee premiums or termination of coverage for cause), or employer contributions towards the other coverage have been terminated.

- **New Dependents.** If You have previously declined enrollment, and You have a new Dependent as a result of marriage, birth, adoption or placement for adoption, or legal guardianship, You may be able to enroll Yourself and Your Dependents, provided that HealthTrust receives a Medical Enrollment Application within 31 days after the marriage, birth, adoption or placement for adoption, or legal guardianship. These special enrollment rights are in addition to Your right to add Dependents to Your existing coverage as described elsewhere in this Section.

- **Loss of Coverage, or Becoming Eligible for Premium Assistance, under Medicaid or a State's Children's Health Insurance Program.** If You or Your Dependent are eligible but not enrolled under the Plan, You (or Your Dependent) may enroll during the Plan Year in either of the following situations:

    - You or Your Dependent lose coverage under a Medicaid plan (under title XIX of the Social Security Act) or under a State Children's Health Insurance Plan (under title XXI of the Social Security Act) due to loss of eligibility for such coverage; or

    - You or Your Dependent becomes eligible for state funded group health plan premium assistance with respect to this Plan through a state Medicaid or Children's Health Insurance Program.

  You must request enrollment under the Plan by submitting a completed Medical Enrollment Application to HealthTrust within 60 days of the date the other coverage is lost or the date You or Your Dependent is determined to be eligible for premium assistance (whichever is applicable). Coverage for Your or Your Dependent(s) will become effective as of the first of the month following the date coverage is lost or the date of Your Dependent(s) eligibility for premium assistance.

D. **Enrolling New Dependents.** If You are already enrolled, You may enroll any newly eligible Dependent by submitting a Medical Enrollment Application to Your Group Benefits Administrator within 31 days after the Dependent first becomes eligible. Provided HealthTrust receives the Application within 31 days of eligibility, coverage for a newly eligible Dependent (other than a newborn or adopted child) will become effective as of the first day of the month following his/her eligibility date as a Dependent. A newly eligible Dependent is considered enrolled only upon acceptance of the Medical Enrollment Application by HealthTrust. Please see "Newborn Children" and "Adopted Children" below for special effective date rules for newborn and adopted children. If a Medical Enrollment Application is received by HealthTrust after 31 days, but within 60 days, from the date Your Dependents first become eligible, the coverage will become effective the first day of the month following receipt of the Application. If an Application is not received within 60 days, the newly eligible Dependent may not be enrolled until the next open enrollment or a special enrollment period.

1. **Newborn Children.** Your newborn child is covered automatically for Benefits for up to 31 days from the child's date of birth, as long as Your coverage is in effect during that time. In order to continue coverage for Your newborn child after the initial 31 days, You must complete a Medical Enrollment Application to add the child to Your membership as a covered Dependent child. If You do not have a "two person" or "family" membership when Your child is added, You must also indicate on the Application that You want to change Your type of membership (for example, from "two person" to "family" or "single" to "two person" or "family"). To maintain continuous coverage for Your newborn child, You must submit the Application to Your Group Benefits Administrator, and HealthTrust must receive Your Application within 31 days of the child's birth.

- If HealthTrust receives Your Medical Enrollment Application within 31 days of the child's birth, Your change in membership will become effective on the first day of the month following the child's date of birth. If HealthTrust does not receive Your Medical Enrollment Application within 31 days after birth, Your newborn child's eligibility for Benefits will end at midnight on the 31st day after the date of birth.

- If the Application requesting to add the newborn child and/or change membership type is not received by HealthTrust within 31 days, but is received within 60 days of the date of birth, the addition of Your child and/or change in membership type will become effective on the first day of the month following HealthTrust's receipt of the Application. In this situation, no Benefits are available for services that Your newborn child receives between the end of the initial 31 days of coverage and the effective date of Your child's membership as a covered Dependent child. If an Application is not received within 60 days, the newly eligible Dependent may not be enrolled until the next open enrollment or a special enrollment period.

If Your covered Dependent child gives birth, Your newborn grandchild is eligible for Benefits for up to 31 days following the newborn child's date of birth. You cannot add the grandchild to Your membership unless You adopt or become the legal guardian of the grandchild.

2. **Adopted Children.** Your adopted child is eligible for Benefits as of the date of adoption or placement for adoption. For Your adopted child to receive coverage from the date of adoption or placement for adoption, You must complete a Medical Enrollment Application and submit the Application to Your Group Benefits Administrator within 31 days of the date of adoption or placement for adoption. The Application must show Your child's name, date of birth, and date of adoption or placement for adoption. For purposes of this Section, "placement for adoption" means that the child for whom You are the proposed adoptive parent has been lawfully placed in Your custody pursuant to an adoption proceeding under the provisions of applicable law before the adoption becomes final. If You do not have a "family" membership when Your adopted child is added, You must also indicate on the Application that You want to change Your type of membership (for example, from "two person" to "family" or "single" to "two person" or "family").

- If HealthTrust receives Your Medical Enrollment Application within 31 days of the child's adoption, or placement for adoption, coverage of the child will become effective on the date of adoption or placement for adoption and any change in membership type will become effective on the first day of the month following the child's date of adoption or placement for adoption.

- If the Application requesting to add the adopted child and/or change membership type is not received by HealthTrust within 31 days, but is received within 60 days of the date of adoption or placement for adoption, coverage of Your adopted child and any change in membership type will become effective on the first day of the month following HealthTrust's receipt of the Application. If an Application is not received within 60 days, the newly eligible Dependent may not be enrolled until the next open enrollment or a special enrollment period.

E. **Qualified Family Status Changes.** You may enroll or remove Dependents and/or change Your type of membership ("single," "two person," or "family") during a Plan Year provided that such change is due to and consistent with a qualified family status change. A qualified family status change includes any of the following events:

- Marriage
- Birth
- Adoption or placement for adoption
- New legal guardianship
- Divorce or legal separation
- A change in a Dependent's eligibility
- A change in Your employment status or that of Your spouse that affects Your health plan coverage
- A significant change in Your health plan cost or coverage, or that of Your spouse's, relating to that individual's employment status or coverage
- Your spouse's employer holds open enrollment at a time other than Your employer — and, as a result of its benefit offerings, You would like to make a change (if Your Group recognizes this as a qualified change in status)
- Death

Your Group and HealthTrust will not automatically change Your type of membership. You must request any desired change in membership and promptly notify Your Group of any Dependents to be added or removed from Your membership under the Plan. A request to change membership type and/or to enroll or remove Dependents should be made by submitting a Medical Enrollment Application to Your Group within 31 days of the qualified family status change.

If a Medical Enrollment Application requesting to enroll Dependents and/or to change membership type is received by HealthTrust within 31 days of a qualified family status change, the requested change(s) will take effect on the first of the month following the date of the event. If the Application is not received by HealthTrust within 31 days but is received within 60 days from the date of the qualified family status change event, the requested change will become effective the first of the month following receipt of the Application. If a request is not made within 60 days, coverage for Your Dependents and membership type may not be changed until the next open enrollment or a special enrollment period.

F. **Additional Rules.** The following rules apply in addition to those described above:

1. **Medicare Eligibility.** If You or any of Your Dependents become eligible for Medicare, You must contact Your Group Benefits Administrator. Please see Section 10, I, C, "Medicare Program," for more information.

2. **Effective Date for Benefits.** The effective date of Your coverage under this Certificate is determined by Your Group and HealthTrust pursuant to the rules described above in this Section. After Your coverage under this Certificate begins, Benefits are available according to the coverage in effect on the "date of service." For purposes of this Certificate "date of service" means:

- For Inpatient hospital *facility* charges, the date of admission;

- For Inpatient *professional* services (such as Inpatient medical care or surgery furnished by a Provider), the date You receive the care;

- For professional maternity care (prenatal care, delivery of the baby and postpartum care), the date of delivery, provided that the total maternity care was furnished by one Provider; and

- For Outpatient services (such as emergency room visits, Outpatient hospital care, office visits, physical therapy or Outpatient surgery, etc.), the date You receive the care.

3. **Your Responsibility to Provide Notice of Changes.** It is Your responsibility to inform Your Group and HealthTrust of changes in Your or any of Your Dependent's name or address. It is also Your responsibility to inform Your Group and HealthTrust 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 article IV of this Section.

   Name changes and enrollment changes must be made through Your Group Benefits Administrator. You will be required to sign a Medical Enrollment Application in order to effect the change. Failure to timely notify Your Group Benefits Administrator of changes in the eligibility status of You or any of Your Dependents may result in a cancellation of coverage or delay in enrollment for You or Your Dependents.

   For a change of address, contact Your Group Benefits Administrator or HealthTrust at:

   HealthTrust
   PO Box 617
   Concord, NH 03302-0617
   1-800-527-5001

4. **Disclosing Other Coverage.** As another condition of enrollment and coverage under the Plan, You agree to provide information to Your Group and HealthTrust regarding any other health coverage under which You and/or Your Dependents are entitled to benefits. Your receipt of benefits through another health care plan may affect Your Benefits under this Certificate. Please see Section 10 for more information about how Benefits are determined when You and/or Your Dependents are covered under more than one health plan coverage, including Medicare.

III. Termination of Coverage

A. **General.** This article describes circumstances under which Your coverage under the Plan will terminate. Whether or not You or Your Group contacts HealthTrust to effect any of the terminations in this article, HealthTrust will administer the terminations if HealthTrust has knowledge of the termination event. Subject to any right to continuation of coverage as described in article IV of this Section, Benefits under this Certificate, including Benefits for services rendered after the date of termination for medical conditions arising prior to the date of termination, shall automatically terminate at midnight on the earliest of the dates specified in subsection B below. In no event are Benefits available for Covered Services rendered or delivered after the date coverage under the Plan terminates.

Enrollment under the Plan 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, sexual orientation or identity, gender, or evidence of insurability (including conditions arising out of domestic violence).

Under certain circumstances, You and Your covered Dependents who are no longer eligible for coverage are entitled to continue coverage under the Plan (or convert to an individual policy). Please see article IV below for more information.

B. **Termination Events and Dates.** Coverage will automatically terminate for You and/or Your Dependents at midnight on the earliest of the following dates:

- The date this entire Plan is terminated by HealthTrust. HealthTrust may, at its discretion at any time, discontinue this Plan as long as You and Your Group are given 30 days advance notice;

- The date as of which Your Group terminates Your Group's (or Your subunit of Your Group) participation in the Plan;

- The end of the month in which You or Your enrolled Dependents no longer meet the eligibility requirements for coverage under the Plan, or such other date as of which Your Group Benefits Administrator notifies HealthTrust to terminate Your coverage;

- The date specified by HealthTrust that Your (and Your enrolled Dependents') coverage will end because You or Your Group failed to pay any required premium or other contribution for Your coverage under the Plan;

- The date of Your or Your eligible Dependent's enrollment (or such other date as specified by HealthTrust and allowed by law) if HealthTrust or Anthem determines that You have engaged in any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact related to Your eligibility or enrollment, on, or with respect to, the Medical Enrollment Application or other required documentation in obtaining or maintaining coverage under the Plan;

- The date HealthTrust determines that You or Your enrolled Dependent(s) have failed to comply with the procedures and requirements set forth under the provisions of Section 10 "Other Party Liability" of this Certificate;

- The date specified by HealthTrust in a notice of cancellation or nonrenewal of Your Group's participation in the Plan or in HealthTrust, sent to Your Group by HealthTrust, due to Your Group's failure to meet HealthTrust's minimum employee participation requirements or other requirements under the Group's membership agreement with HealthTrust; or

- The date established by HealthTrust for other causes as permitted by law. Cause may include failure to disclose other health plan coverage, fraud committed by a Member in connection with any claim filed under this Certificate, or if an unauthorized person is allowed to use any Member's identification card or if a Member otherwise cooperates in the unauthorized use of such Member's identification card.

C. **Additional Rules for Certain Termination Events.** The following additional rules apply with respect to certain termination events:

1. **Your Death.** Your coverage will terminate on the date of Your death. Please see article IV of this Section for information about how covered surviving spouses and other covered Dependents can elect to continue coverage following Your death.

2. **Termination of Your Marriage.** If You become divorced or legally separated, the coverage of Your spouse will terminate at the end of the month which includes the date of divorce or legal separation. You must submit a Medical Enrollment Application indicating a change in marital status within 31 days of such change. However, Your failure to submit an Application does not prohibit Your Group or HealthTrust from terminating the enrollment of an individual who no longer meets the definition of a covered spouse. Please see article IV of this Section for information about how Your former spouse and other covered Dependents can elect to continue coverage.

3. **Termination of a Dependent Child's Coverage.** A Dependent child's coverage under this Certificate will terminate at the end of the month which includes the date on which the child no longer satisfies the eligibility requirements of a Dependent child as set forth in article I of this Section. You must submit a Medical Enrollment Application within 31 days of such event. However, Your failure to submit an Application does not prohibit Your Group or HealthTrust from terminating the enrollment of an individual who no longer meets the definition of a covered Dependent child. Please see article IV of this Section for information about how Your covered Dependent child can elect to continue coverage.

IV. Continuation of Group Coverage

This article explains some of the ways You and Your covered family members can choose to continue coverage through Your Group when coverage under the Plan would otherwise end. A separate document which describes these continuation rights in further detail is provided to You and Your covered spouse (if You are married) upon initial enrollment in the Plan.

A. **Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).** COBRA is a federal law which requires Your Group to offer You and Your enrolled Dependents ("qualified beneficiaries") the opportunity to continue group coverage under the Plan for a temporary period, at Your expense, when Benefits would otherwise end because of certain "qualifying events."

COBRA continuation rights under the Plan are available only through Your Group. HealthTrust assists Your Group with certain COBRA notice and other administrative requirements.

1. **Qualifying Events.** You and Your enrolled Dependents will become qualified beneficiaries if Your coverage under the Plan would otherwise end due to one of the following qualifying events:
   - Your hours of employment are reduced; or
   - Your employment ends for any reason other than gross misconduct.

   Additionally, Your enrolled Dependents will become qualified beneficiaries if their coverage would otherwise end due to one of the following qualifying events:

   - You, the Subscriber, die;
   - You divorce or legally separate;
   - You become entitled to Medicare benefits (under Part A, Part B, or both); or
   - In the case of a child, he or she is no longer an eligible Dependent under the Plan.

2. **Notices and Election Rights**. COBRA coverage is available under the Plan to qualified beneficiaries only after Your Group and HealthTrust have been notified that a qualifying event has occurred. You or an eligible family member who is a qualified beneficiary must notify Your Group Benefits Administrator within 60 days of the date coverage under the Plan would otherwise end due to Your divorce, legal separation or a child losing status as an eligible Dependent. If the Participating Group and HealthTrust are not notified of these qualifying events within the 60-day notice period, any eligible family member who loses coverage will not be offered the right to elect continuation coverage.

   Once You notify Your Group of the qualifying event, Your Group will then notify HealthTrust. Your Group also must notify HealthTrust of other qualifying events including Your death, termination of employment, reduction in hours of employment, or Medicare entitlement.

   After HealthTrust receives notice that a qualifying event has occurred, HealthTrust will provide notice to eligible qualified beneficiaries of their right to elect COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA coverage and will have until the **later of** the following dates to make their election:

   - 60 days after the date their coverage would otherwise end due to the qualifying event; or
   - 60 days after the date the qualified beneficiary receives notice of the right to elect COBRA coverage.

   If COBRA coverage is not elected by the election deadline, all COBRA rights will be forfeited and no continuation coverage will be available to the qualified beneficiary.

3. **Nature of Continuation Coverage**. If You or Your covered family members elect COBRA, You generally will receive the same coverage and enrollment rights as are provided to similarly situated active employees of Your Group and their family members.

4. **Duration of Continuation Coverage**. COBRA coverage is a temporary continuation of coverage under the Plan. The maximum period of COBRA coverage will depend on the nature of the qualifying event as follows:

   - **18 months** if the qualifying event is Your termination of employment or reduction in hours of employment (the 18-month period may be extended to 29 months if a qualified beneficiary is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA coverage); or

   - **36 months** if the qualifying event is Your death, divorce or legal separation, Medicare entitlement, or a child losing Dependent status.

   - **Additional non-COBRA continuation period for former or surviving spouses**. In addition to the maximum COBRA coverage period, the following continuation periods are available under the Plan:

i. If the qualifying event is divorce or legal separation and the former spouse is a qualified beneficiary age 55 or older at the time of the relevant court decree, the maximum continuation period will extend until the former spouse becomes eligible for coverage under another group health plan or Medicare; or

ii. If the qualifying event is Your death and Your surviving spouse is a qualified beneficiary age 55 or older at the time of Your death, the maximum continuation period will extend until Your surviving spouse becomes eligible for coverage under another group health plan or Medicare.

Please note: The Plan does not provide additional continuation coverage rights to former spouses under NH RSA 415:18, VII-b.

COBRA coverage will terminate prior to the maximum coverage period upon certain termination events which apply under COBRA law. Eligibility for COBRA coverage under the Plan will end if Your Group terminates participation in the Plan for its active employees.

5. **Cost of Continuation Coverage.** You and other eligible qualified beneficiaries will be obligated to pay the full premium cost for COBRA or other continuation coverage, unless Your Group has other premium payment arrangements. An administrative fee as allowed by law may also apply. Specific information regarding the premium costs and payment terms for continuation coverage will be included in the COBRA election notice provided upon a qualifying event.

B. **Continuation of Coverage Due to Military Service (USERRA).** In the event You are no longer actively at work because You are called to military service in the Armed Forces of the United States, You may elect to continue health coverage for You and Your enrolled Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). "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 You and Your enrolled Dependents (if any) under the Plan. You may be obligated to pay the full premium cost (and any applicable administrative fee) for continuation coverage under the Plan. This may include the amount Your Group normally pays on Your behalf. If Your military service is for a period of less than 31 days, You may not be required to pay more than the active employee contribution, if any, for the continuation coverage. If continuation is elected under this provision, the maximum period of continuation coverage under the Plan shall be the lesser of:

- 24 months; or
- Your period of military service (measured from the date the military service begins and ending on the day after the date on which You fail to apply for re-employment or return to employment with Your Group).

Whether or not You elect continuation coverage, if You return to Your position of employment, Your and Your eligible Dependents' coverage under the Plan will be reinstated. No Probationary Period or exclusions 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 Veteran Affairs to have been incurred in, or aggravated during, the performance of military service.

For more information regarding COBRA and other continuation coverage rights and obligations, please contact Your Group Benefits Administrator or HealthTrust, or refer to the COBRA information document provided to You upon initial enrollment. If You would like a current version of the COBRA initial notice, please contact HealthTrust.

SECTION 14: DEFINITIONS

This Section defines some of the specially capitalized words and phrases found throughout this Certificate:

Adverse Benefit Determination means the Plan's denial, reduction, or termination of, or a 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 an individual's eligibility for coverage under this Certificate. Adverse Benefit Determination also includes the Plan's denial, reduction, or termination of, or a 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 the Plan's determination not to cover an item or service for which Benefits are otherwise provided based on a determination that the item or service is Experimental, Investigational or not Medically Necessary or appropriate, as well as a rescission of coverage.

Ambulatory Surgical Center means A facility licensed as an Ambulatory Surgical Center as required by law that must satisfy Anthem's accreditation requirements and be approved by Anthem.

Anniversary Date means the first day of the Group's Plan Year. The Anniversary Date is January 1 for Groups with a January Plan Year and July 1 for Groups with a July Plan Year.

Anthem means Anthem Health Plans of New Hampshire, Inc., doing business as Anthem Blue Cross and Blue Shield, which is licensed in the State of New Hampshire as a third party administrator. HealthTrust has contracted with Anthem to provide certain services, including claims processing, administration and utilization management services, for this managed health care Plan.

Behavioral Health Care means Covered Services provided to treat Mental Disorders and Substance Use Disorders as defined in Section 7, V, "Behavioral Health Care (Mental Health and Substance Use Care)."

Benefit(s) 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 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.

Certificate means the Plan documents which describe the terms and conditions of coverage under this managed health care Plan. The Certificate includes the Subscriber Certificate (this document), Your Medical Enrollment Application, Your identification card, Your Cost Sharing Schedule and any endorsements, riders or amendments to the Subscriber Certificate.

Community Mental Health Center means 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.

Cost Sharing Schedule means the document that lists the cost sharing amounts that apply under Your Plan. Your Cost Sharing Schedule is a part of Your Certificate.

Covered Service(s) means the services, products, supplies or treatment specifically described as being eligible for Benefits in this Certificate that are given to You by a Provider. 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;
- Within the scope of the Provider's license;
- Given while You are covered under the Plan;
- Not Experimental or Investigational or otherwise excluded or limited under the terms of this Certificate; and

- Provided in accordance with the Plan rules stated in this Certificate. Otherwise, a service may not be a Covered Service. Plan rules include, but are not limited to, rules such as those pertaining to services furnished by Network Providers and requirements about Precertification or Preauthorization from Anthem.

Dependent means a person who is eligible to be enrolled under the Plan as a dependent of the Subscriber under the provisions of Section 13.

Designated Network means a group of PCPs, hospitals, facilities, specialists, suppliers and any other health care practitioners all having a written agreement directly with the same affiliated New England Blue Cross and Blue Shield Plan to provide Covered Services to Members.

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, but are not limited to, 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.

Diabetes Education Provider means a certified, registered or licensed health care expert in diabetes management who furnishes diabetes counseling and diabetes education to Members.

Employee means any person who is described as an employee in the governing documents applicable to HealthTrust other than a person who is so described solely by reason of being a spouse or dependent. Generally, "Employee" will include, in whole or in part as each Group may determine, any person who is (1) actively engaged in employment with a Group on a Full-Time or a Part-Time basis, (2) a Retiree or on leave of absence, or (3) a qualifying publicly elected or appointed official of a Group. For purposes of (1) above, a person is employed (a) on a "Full-Time" basis if he or she is a full-time employee working 30 or more hours a week for the Group or otherwise satisfies the definition of a "full-time employee" for purposes of Section 4980H(c)(4)(A) of the Internal Revenue Code of 1986, as amended by the Affordable Care Act of 2010, and (b) on a "Part-Time" basis if he or she is working a minimum of 15 hours per week for the Group.

Experimental or Investigational means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which Anthem determines to be experimental or investigational as defined in Section 8, II.

Group means any New Hampshire municipality, county, school district, or other political subdivision or instrumentality thereof which is a member of HealthTrust and is offering health care coverage under the Plan to its eligible Employees and their Dependents. Your Group is Your employer.

Group Benefits Administrator means the person at Your place of employment who handles health plan benefits for Your Group.

HealthTrust means HealthTrust, Inc., a New Hampshire voluntary corporation.

Home Health Care Agency means a Provider licensed when required by law and approved by Anthem, that:
- Gives skilled nursing and other services on a visiting basis in Your home; and
- Supervises the delivery of services under a plan prescribed and approved in writing by the attending Provider.

Inpatient means care received while You are a bed patient in a hospital, Skilled Nursing Facility or Physical Rehabilitation Facility.

Intensive Outpatient Program means structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Local Plan means the affiliated New England Blue Cross and Blue Shield plan that administers written agreements made directly between the Local Plan and Network Providers in a Designated Network.

Maximum Allowed Amount means the maximum amount of reimbursement the Plan will allow for Covered Services. For more information, see Section 9, I, "Maximum Allowed Amount."

Medical Child Support Order means, in accordance with New Hampshire RSA 161-H:1, any valid judgment or order to provide health coverage for a dependent child of the Subscriber issued by any court or administrative body of the State of New Hampshire or any other state including an order in a final decree of divorce.

Medical Director means a physician licensed under New Hampshire law, employed by Anthem, and responsible for Anthem's utilization review techniques and methods and their administration and implementation.

Medical Enrollment Application (Application) means the application form that must be completed, signed and submitted to Your Group Benefits Administrator. An applicant is enrolled under the Plan only upon acceptance of the Medical Enrollment Application by HealthTrust. This form is also used to notify HealthTrust of changes in membership and enrollment information.

Medically Necessary or Medical Necessity means health care services or products provided to a Member 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 Member or the Provider.

Please note: The fact that a 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.

When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a specialty drug provided in the Outpatient department of a Hospital if the drug could be provided in a Provider's office or the home setting.

You have the right to appeal Benefit determinations made by Anthem or its delegated entities, including Adverse Benefit Determinations regarding Medical Necessity. Please refer to the appeal procedures in Section 11 for more information.

Member means the Subscriber and any Dependent covered under the Plan.

Network Behavioral Health Provider means a hospital or other Eligible Behavioral Health Provider, as defined in Section 7, V, C, who has an agreement directly with Anthem or another Local Plan to provide Behavioral Health Care to Members.

Network New Hampshire Certified Midwife (Network NHCM) means an individual who is certified under New Hampshire law and who has a written agreement directly with Anthem to provide Covered Services to Members.

Network Provider means any Provider that has a written agreement, directly or indirectly, with Anthem or another Local Plan to provide Covered Services to Members**.** A Provider that is In-Network for one Plan might not be In-Network for another.

Network Services means Covered Services that You receive from a Network Provider.

Out-of-Network Provider means a Provider that does not have an agreement or contract, directly or indirectly, with Anthem or another Local Plan to provide Covered Services to Members.

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.

Partial Hospitalization Program means a structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Physical Rehabilitation Facility means a state authorized and licensed facility for physical rehabilitation services where short-term active professional care is provided.

Plan means HealthTrust's Access Blue New England managed health care plan, as described in this Certificate, which is offered by Your Group to eligible Employees and their eligible Dependents.

Plan Year means the twelve-month period selected by Your Group for its participation in the Plan. Each Group will select either a January (January 1 through December 31) or July (July 1 through June 30) Plan Year. The initial Plan Year for each Group will be the period beginning with the first of the month in which participation in the Plan begins and ending with the next December 31 or June 30, depending on whether the Group selects a January or July Plan Year. Thereafter, the Plan Year will be each successive twelve-month period.

Post-Service Claim means any claim for a Benefit for which the terms of the Plan do not condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining the medical care. "Post-Service Claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and Anthem.

Precertification (or Preauthorization) means Anthem's or the Local Plan's written confirmation that a service is Medically Necessary. Your Provider may be required to contact Anthem or the Local Plan for Precertification (or Preauthorization) before You receive certain Covered Services. Precertification (or Preauthorization) is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Certificate that are in effect on the date You receive Covered Services.

Pre-Service Claim means any claim for a Benefit under the Plan with respect to which the terms of the Plan condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining the medical care. "Pre-Service Claim" shall not include a request for reimbursement made by a Provider pursuant to the terms of an agreement between the Provider and Anthem.

Primary Care Provider (PCP) means a Network Provider who gives or directs health care services for You. PCPs include internists, family/general practitioners, Advanced Practice Registered Nurses (APRN), and pediatricians or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to You and is in charge of Your ongoing care.

Prior Approval means the process by which You or Your Provider may request that Anthem review proposed services to determine if services are Covered Services. Prior Approval differs from Precertification because it is a voluntary request for Anthem's review. Prior Approval is not a step that either You or Your Provider are required to take under the terms of this Certificate.

Private or Public Hospital means 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.

Probationary Period means the period of time established by Your Group that You must work before You are eligible to enroll for coverage under this Plan.

Provider means a healthcare professional or facility that is duly licensed or certified as required by law in the state which regulates their licensure and practice and each acting within the applicable scope or license or certification, and is approved by Anthem. Providers of Covered Services are described throughout this Certificate. This also may include unlicensed behavioral health Providers as permitted by law and that meet the criteria as described in this Certificate. If You have a question about a Provider not described in this Certificate, please contact Anthem Member Services at the number on Your identification card.

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

Referral means a specific recommendation by a Member's PCP or Network Provider that the Member should receive evaluation or treatment from a specific Provider. A recommendation from a PCP or Network Provider is a Referral only to the extent of the specific services approved and referred by the PCP or Network Provider on the

written referral form or by other notification methods prescribed by Anthem for use by PCPs and Network Providers. A general statement by a PCP or Network Provider that a Member should seek a particular type of service or Provider does not constitute a Referral. A Referral does not guarantee or imply coverage for those services or procedures.

Residential Treatment Center means an inpatient facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorder conditions. The facility must be licensed as a residential treatment center in the state in which it is located, satisfy Anthem's accreditation requirements, and be approved by Anthem.

The term Residential Treatment Center does not include a Provider, or that part of a Provider, used mainly for any of the following:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic means a facility that provides care for limited basic health care services to Members on a "walk-in" basis. These clinics are often found in major pharmacies or retail stores. Health care services are typically provided by physician assistants or Advanced Practice Registered Nurses. Services are limited to routine care and treatment of common illnesses for adults and children.

Retiree means a person who is retired from active employment with a Group and who the Group determines is eligible to continue coverage under the Plan pursuant to NH RSA 100-A:50 and/or applicable HealthTrust and Group rules governing eligibility for Retiree coverage.

Service Area means the geographic area where You can get Covered Services from a Network Provider. For purposes of this Plan, the Service Area is the geographic area within which all Designated Networks combined are located.

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 inpatient facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a Skilled Nursing Facility in the state in which it is located, satisfy Anthem's accreditation requirements and be approved by Anthem.

Subscriber means You, the Employee or Retiree, who is properly enrolled and accepted for coverage under the Plan.

Substance Use Disorder Treatment Provider means 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 Use Disorder rehabilitation, and is affiliated with a hospital under a contractual agreement with an established patient referral system, or is accredited by The Joint Commission (TJC) on Accreditation of Hospitals as a Substance Use Disorder Treatment Provider.

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 Provider 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 health care facility whose main purpose is providing immediate, short-term, urgent health services for diagnosis, care and treatment of illness or injury. An Urgent Care Facility may be free-standing or a facility located in the Outpatient department of a hospital. Please see Section 6, "Urgent and Emergency Care," for more information about Urgent Care.

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.

You or Your means You, the person to whom this Certificate is issued (the Subscriber), Your covered spouse and other covered Dependents - collectively the Members, unless specifically stated (or where the context provides) otherwise.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act as well the Provider transparency requirements that are described below.

Surprise Billing Claims

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

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under the Plan:

- Without the need for Precertification;
- Whether the Provider is In-Network or Out-of-Network;

If the Emergency Services You receive are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if You receive Emergency Services from an Out-of-Network Provider, Your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and / or Coinsurance) will apply to Your claim if the treating Out-of-Network Provider determines You are stable, meaning You have been provided necessary Emergency Care such that Your condition will not materially worsen and the Out-of-Network Provider determines: (i) that You are able to travel to an In-Network facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) You are in condition to receive the information and provide informed consent. If You continue to receive services from the Out-of-Network Provider after You are stabilized, You will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge You any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges.

This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When You receive Covered Services from an Out-of-Network Provider at an in-network facility, Your claims will be paid at the Out-of-Network benefit level if the Out-of-Network Provider gives You proper notice of its charges, and You give written consent to such charges. This means You will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge You any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges.

This notice and written consent process does not apply to Ancillary Services. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this notice and consent process to You if Anthem does not have an In-Network Provider in Your area who can perform the services You require.

Out-of-Network Providers will satisfy the notice and consent requirement as follows:

1. By obtaining Your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if You make a follow-up appointment within 72 hours of the services being delivered.

Continuity of Care

If Your In-Network Provider leaves our network for any reason other than termination for cause, or if coverage under this Plan ends because Your Group's contract ends, or because Your Group changes plans, and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still get In-Network benefits.

"Active treatment" means ongoing courses of treatment (including treatments for Mental Health and Substance Use Disorders) for:

1) An ongoing course of treatment for a life-threatening condition, including chronic illness or condition. A chronic illness or condition is a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time,

2) An ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy, and post-operative visits),

3) An ongoing course of treatment for pregnancy through the postpartum period,

4) A scheduled non-elective surgery from the Provider, including receipt of postoperative care from such Provider or facility with respect to such a surgery, or

5) An ongoing course of treatment for a health condition for which the physician or health care Provider attests that discontinuing care by the current physician or Provider would worsen Your condition or interfere with anticipated outcomes, or

6) Continuing care benefits for Members undergoing a course of institutional or Inpatient care from a Provider or facility and/or determined to be terminally ill and is receiving treatment for such illness from such Provider or facility.

An "ongoing course of treatment" includes treatment for Mental Health and Substance Use Disorders.

In these cases, You may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If You wish to continue seeing the same Provider, You or Your doctor should call Anthem Member Services for details. Any decision by Anthem regarding a request for Continuity of Care is subject to the appeals process described in Section 11 of this Certificate.

Provider Directory Accuracy

Anthem is required to confirm the list of In-Network Providers in its Provider Directory monthly. If You received inaccurate information from Anthem that a Provider was In-Network on a particular claim, then You will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost-shares will be calculated based upon the Maximum Allowed Amount.

How Cost-Shares Are Calculated

Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network facility will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. Any Out-of-Pocket cost shares You pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network facility will be applied to Your In-Network Out-of-Pocket Limit.

Out-of-Network Providers may send You a bill for charges, including those that may exceed the Plan's Maximum Allowed Amount. If You receive such a bill, please contact Anthem Member Services before You pay the bill. You are not responsible for any amount above Your In-Network cost share amount.

Appeals

If You receive Emergency Services from an Out-of-Network Provider, Covered Services from an Out-of-Network Provider at an In-Network facility, or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprise Billing Act but the claims were not covered as such, You have the right to appeal that claim. If Your appeal of a Surprise Billing Claim is denied, then You have a right to appeal the

adverse decision to an Independent Review Organization as set out in the "Member Satisfaction Services, Internal Appeal Procedure and External Review" Section of this Subscriber Certificate.

Transparency Requirements

HealthTrust and Anthem provide the following information on their websites (www.healthtrustnh.org, and www.anthem.com):

- Protections with respect to Surprise Billing Claims by Providers; including information on how to contact state and federal agencies if You believe a Provider has violated the No Surprises Billing Act.
- Estimates on what Out-of-Network Providers may charge for a particular service (Anthem website only);
- Information for contacting state and federal agencies in case You believe a Provider has violated the No Surprise Billing Act's requirements.

Upon request, HealthTrust and/or Anthem will provide You with a paper copy of the type of information You request from the above list.

You can obtain the below information from Anthem, either through its price comparison tool on www.anthem.com or through Anthem Member Services at the phone number on Your identification card:

- Cost sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing/directory of all In-Network Providers.

Anthem will provide access through its website to the following information:

- In-Network negotiated rates; and
- Historical Out-of-Network rates.

Nondiscrimination in Health Care Notice

HealthTrust complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HealthTrust does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

HealthTrust provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If You need communication assistance, contact Anthem Member Services at the number on Your identification card.

HealthTrust

Anthem

ACUPUNCTURE ENDORSEMENT

This Endorsement amends Your Access Blue New England Subscriber Certificate. Except as stated in this Endorsement, all other terms and conditions of Your Certificate apply.

Section 7, III, "Outpatient Physical Rehabilitation Services" is amended to include coverage for acupuncture services by adding the following subsection G:

G. **Acupuncture**. Benefits are available for the treatment of neuromusculoskeltal pain by an acupuncturist who acts within the scope of their license. Covered Services must be furnished by a licensed acupuncturist or other individual licensed to provide acupuncture services. For example, a chiropractor or physical therapist must be licensed for acupuncture. For assistance in locating a provider, please contact Anthem Member Services at the toll-free telephone number on Your identification card.

Acupuncture may be subject to a Visit Copayment and may be limited to a specific number of visits each Plan Year. Please refer to Your Cost Sharing Schedule.

Scott DeRoche

Scott DeRoche
Executive Director
HealthTrust, Inc.

Maria M. Proulx

Maria M. Proulx
President and General Manager
Anthem Blue Cross Blue Shield, New Hampshire

HealthTrust Notice of Privacy Practices

Protecting Your Health Information is Important to Us.

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that HealthTrust inform you of our privacy practices regarding your protected health information (PHI). We are fulfilling that requirement with this Notice, which applies to our medical and dental plans, as well as services provided for healthcare flexible spending accounts and health reimbursement arrangements. This Notice does not apply to our short-term disability, long-term disability, and life coverages, however protecting all personal information is important to us.

Uses and Disclosures

This section describes how we typically use or disclose your protected health information (PHI).

For Payment Activities: We may use or disclose your PHI for billing and payment (for example, by providing an invoice or information to your participating employer group to collect premiums or confirm coverage for those billed on the invoice).

For Treatment: While HealthTrust does not provide treatment, we may use or disclose your PHI for the coordination of your healthcare coverage (for example, by confirming your coverage with a treating physician).

For Healthcare Operations: We may use or disclose your PHI for the administration of your health plan coverage or quality improvement initiatives. For example, we may share enrollment information or summary information related to the creation, renewal, or replacement of your health benefits with your participating employer group. Enrollment information may include information you would be asked to provide to your participating employer group upon enrollment and any updates to that information. Further, in administering HealthTrust medical and dental plans, HealthTrust will not disclose information to an employer about individual claims or diagnosis unless permitted by a written authorization or otherwise required or permitted by law.

To Business Associates: We may disclose your PHI to our Business Associates, who assist with our operations and have provided written assurance that they will safeguard your information (for example, by sharing eligibility information with the claims administrator).

To Other HIPAA Covered Entities: We may disclose your PHI to other HIPAA covered entities that have a relationship with you (for example, to a medical provider who is treating you).

For Plan Administration: We may disclose certain information to the Plan Sponsor provided they have agreed to safeguard PHI. For example, if your employer group contracts with us to assist in administering its healthcare flexible spending account plan, we may share your information with them for administration of that plan.

As Required by Law or Authorized for Oversight Activities: We may use or disclose your PHI when required by law or authorized by law for public health and public benefit oversight. Examples may include to comply with a court order, to avert an imminent threat to health and safety, for regulatory oversight by federal or state authorities, for research purposes, or as authorized by workers' compensation laws.

Upon Your Authorization: We will not use or disclose your PHI other than described here, or as permitted under applicable laws, unless you provide written notice authorizing the use or disclosure. You may revoke the authorization at any time.

In certain situations, you can also tell us your preference about disclosure of certain information - for example, sharing information with family or friends involved in payment for your care or sharing information in a disaster relief situation or medical emergency. However, if you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Your Rights

This section describes your rights regarding the protected health information we maintain.

Inspect and Copy: You can ask to inspect or copy your PHI that we maintain. We may charge a reasonable, cost-based fee for copies.

Amend: If you think your records are incorrect, you can ask us to amend them. We are not required to honor this request, but must respond within 60 days.

Confidential Communication: You can request we contact you in a specific way or send mail to a different address. We will consider all reasonable requests.

Restrictions: You can request we not share certain PHI for treatment, payment, or healthcare operations; however, we have the right to say no to the request.

Accounting of Disclosures: You can request a list of disclosures of your PHI made for reasons other than treatment, payment, healthcare operations, or made to you or with your authorization.

Copy of this Notice: You can ask for a paper copy of this Notice at any time.

Personal Representative: If you have given someone power of attorney or if someone is your legal guardian, that person can exercise your rights on your behalf.

File a Complaint: If you believe that we have violated your privacy rights, you may file a complaint in writing with the HealthTrust Privacy Officer. You may also submit a complaint with the Office for Civil Rights of the US Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Our Responsibilities

This section describes our responsibilities related to your protected health information.

Safeguard Your Information: We are required by law to protect your health information, and will follow the duties and privacy practices described in this Notice.

Notification: We will alert you promptly if a breach occurs that may have compromised the privacy or security of your PHI.

Minimum Necessary: When using or disclosing your PHI we will make reasonable efforts to use or disclose the minimum amount of information needed to accomplish the intended purpose. Some disclosures such as those made to you, the US Department of Health and Human Services, or as required by law are not held to the minimum necessary standard.

Marketing, Sales, and Fundraising: We do not use, disclose or sell your PHI for any marketing, sales, or fundraising activity, nor would we do so without your written authorization or as permitted by applicable law.

Genetic Information. We do not use or disclose genetic information for underwriting purposes.

Psychotherapy Notes: We do not maintain any psychotherapy notes. If our Business Associates have these notes, they will not disclose them without your written authorization.

If you have any questions, need further information regarding this Notice, or if you wish to receive another copy, please contact:

Privacy Officer
HealthTrust, Inc.
PO Box 617
Concord, NH 03302-0617
800.527.5001 (Toll-Free) 603.226.2861 (Local)
privacyofficer@healthtrustnh.org

HealthTrust can change the terms of this Notice, and the changes will apply to all protected health information we have about you. The current version of the Notice is available on our website at *www.healthtrustnh.org*. This Notice is effective as of July 1, 2019 and replaces HealthTrust's previous Notice dated January 12, 2015.

It’s important that Anthem treats you fairly

That’s why Anthem follows federal civil rights laws in our health programs and activities. Anthem does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, Anthem offers free aids and services. For people whose primary language isn’t English, Anthem offers free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think Anthem failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf . Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Get help in your language

Curious to know what all this says? Anthem would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD:711).

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Bills from Out-of-Network Ambulance Providers

If you receive ambulance services from an Out-of-Network Provider, Anthem will pay eligible benefits directly to the Out-of-Network ambulance provider or issue a check payable to you and the Out-of-Network Provider. You are responsible for any cost sharing (copayments, deductible, or coinsurance) that may apply under your Plan.

Some Out-of-Network Providers won't accept the amount that Anthem pays them as payment in full. In turn they may bill you for the difference between what they charge and what Anthem pays them. This is called balance billing.

If you or anyone covered by your Plan is balance billed for ambulance services, you should contact Anthem before you pay the bill. Please call Anthem Member Services at the number on the back of your ID card.

X2013NH (7/19) **Rev 01/24**