

Lumenos HSA

Open Access POS

HSA COMPATIBLE
HIGH DEDUCTIBLE HEALTH PLAN

Certificate Booklet

GEHSA25

This High Deductible Health Plan policy is designed to be a federally qualified High Deductible Health Plan (HDHP) compatible with Health Savings Accounts. This contract may qualify you to make a pre-tax annual contribution to a Health Savings Account (HSA).

NOTICE: Anthem Blue Cross and Blue Shield does NOT provide tax advice. The Georgia Insurance Department does NOT in any way warrant that this policy meets the federal requirements.



Underwritten by Anthem Insurance Companies, Inc., a trademark of Blue Cross Blue Shield Healthcare Plan of Georgia, an Independent Licensee of the Blue Cross Blue Shield Association

CERTIFICATE OF COVERAGE

**Anthem Blue Cross Blue Shield
Lumenos HSA
BLUECHOICE OPTION**

**Underwritten by Anthem Insurance Companies, Inc.,
a trademark of Blue Cross Clue Shield Healthcare Plan of Georgia
(herein called Anthem)**

An Independent Licensee of the Blue Cross and Blue Shield Association

**having issued a
Group Master Contract
To**

GEHSA25

hereby certifies that

1. The persons and their eligible family members (if any) whose names are on file at the office of the Plan Administrator as being eligible for coverage, have had the required application for coverage accepted and subscription charge received by Anthem. These persons are covered under and subject to all the exceptions, limitations, and provisions of said Group Master Contract for the benefits described herein;
2. Benefits will be paid in accordance with the provisions and limitations of the Group Master Contract; and
3. Anthem has delivered to the Plan Administrator the Group Master Contract covering certain persons and their eligible family members (if any) as Members of this Group program.

The Group Master Contract (which includes this Certificate Booklet, and any amendments or riders) constitutes the entire Contract. All rights, which may exist, arise from and are governed by this Group Master Contract, and this Certificate Booklet does not constitute a waiver of any of the terms. The Group Master Contract may be inspected at the office of the Plan Administrator.

Coverage under this Certificate will be effective and will continue in effect in accordance with the terms, provisions and conditions of the Group Master Contract. This Certificate of Coverage replaces and supersedes all contracts and/or certificates which may have been issued previously by Anthem through the Plan Administrator. In-Network benefits are provided by Anthem.

The words "we," "us," and "our" refer to to Anthem Blue Cross Blue Shield. The words "you" and "your" refer to the Member, Subscriber and each covered Dependent.



**Monye Connolly,
President**

Table of Contents

Summary of Benefits.....	i
Summary Notice	vii
Important Phone Numbers and Websites	viii
Lifestyle Improvement & Healthy Rewards Incentive Programs	ix
Eligibility.....	1
How Your Benefits Work For You	6
Pre-Admission Certification (PAC) and Outpatient Pre-Certification	9
Benefits.....	11
Mental Health Care and Substance Abuse Treatment	24
Prescription Drug Program	25
Limitations and Exclusions	29
Coordination of Benefits (COB)	34
Right of Recovery	36
Claims and General Information	37
When Your Coverage Terminates	43
Definitions	50
Statement of ERISA Rights.....	63
Mental Health Parity and Addiction Equity Act	66
Statement of Rights Under the Women’s Cancer Rights Act of 1998.....	67

Anthem Lumenos HSA

Summary of Benefits	In-Network	Out-of- Network
Members have direct access to primary and specialty care directly from any In-Network Physician.		
Lifetime Maximums		
Lifetime Maximum Benefits All In-network and Out of-network benefits combined	\$5,000,000	
Lifetime Maximum Benefits for TMJ (included in total maximum) In-network and Out-of-network combined	\$15,000	
Calendar Year Deductible		
Calendar Year Deductible (In-network and Out-of-network combined) Individual – In-network and Out-of-network combined (single coverage)	\$3,000*	
Family – In-network and Out-of-network combined (covering two or more individuals). No more than one individual Deductible per Member	\$6,000*	
* Subject to change based on a yearly index.		
No benefits are payable until the calendar year Deductible is satisfied, unless otherwise indicated.		
All Eligible Charges are subject to the Deductible and Coinsurance except all preventive care services or unless otherwise specified in this booklet.		
All services and all calendar year maximums – whether for a number of days or visits, treatments or a yearly dollar limit – are subject to the Lifetime Maximum Benefit.		
For all services limited to a calendar year benefit maximum – whether for a number of days or visits, treatments or a yearly dollar limit – the In-Network benefit maximums are combined with the Out-of-Network calendar year benefit maximums. These are not separate benefit maximums.		
Out-of-Pocket Limit		
Out-of-Pocket Limit per calendar year (includes the Deductible) Individual (single coverage)	\$5,000*	\$10,000*
Family (covering two or more individuals)	\$10,000*	\$20,000*
*Subject to change based on a yearly index.		
Amounts satisfied toward the Out-of-Network Out-of-Pocket Limit will not be applied toward the In-Network Out-of-Pocket Limit. Amounts satisfied toward the In-Network Out-of-Pocket will not be applied toward the Out-of-Network Out-of-Pocket Limit.		
Percentage Payable (unless otherwise specified) after the applicable calendar year Deductible requirement is met All payments are based on Eligible Charges and negotiated fees.		
The program pays	100%	70%
The Member pays	0%	30%
The percentage payable after the Out-Of-Pocket Limit is met	100%	100%

Summary of Benefits	In-Network	Out-of-Network
Hospital Services		
Pre-certification is required for all Inpatient admissions and specified Outpatient procedures.		
Hospital Inpatient Services Pre-Admission Certification (PAC) is required <ul style="list-style-type: none"> • Daily room, board and general nursing care at semi-private room rate • ICU/CCU charges • Newborn nursery care • Other medically necessary Hospital charges such as diagnostic x-ray and lab services • Physician Services – surgeon, anesthesiologist, radiologist, pathologist 	100%	70%
Outpatient Hospital Services / Ambulatory Surgery Center <ul style="list-style-type: none"> • Facility / Hospital charges including diagnostic x-ray and lab services, surgery and anesthesia • Physician Services – surgeon, anesthesiologist, radiologist, pathologist 	100%	70%
Emergency Room Services <ul style="list-style-type: none"> • Accidental Injury or Medical Emergency <p>Life-threatening medical conditions or serious Accidental Injuries. Initial services rendered for the onset of symptoms for a life-threatening medical condition or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm.</p>	100%	100%
Emergency Room Services, Non-Emergency Use	Not Covered	Not Covered
Professional Ambulance Service (when Medically Necessary) Must be provided by a state-licensed emergency vehicle which carries, via the public streets, injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.	100%	100%
Mental Health Services		
Inpatient Mental Health Care and Substance Abuse Treatment <ul style="list-style-type: none"> • Hospital Inpatient Services • Physician Hospital Services 	100%	70%
Inpatient Substance Abuse Detoxification	100%	70%
Outpatient Mental Health Care and Substance Abuse Treatment	100%	70%
Intermediate Level Mental Health Care <ul style="list-style-type: none"> • Partial Hospitalization Program • Intensive Outpatient Program 	100%	70%

Summary of Benefits	In-Network	Out-of-Network
Physician and Professional Services		
Outpatient Pre-certification is required for specified procedures		
<p>Physician Office Visit</p> <p>Primary Care Physician / Specialist Physician</p> <ul style="list-style-type: none"> • Lab • X-ray • Surgery and professional services performed in the office • Allergy care – includes testing, serum and shots 	100%	70%
<p>Preventive Care</p> <p>Preventive Services for Children Age 5 and Under</p> <p>The Deductible does not apply to child wellness services (both In- and Out-of-network) for children through age 5.</p> <p>Services include but are not limited to:</p> <ul style="list-style-type: none"> • Periodic Health Assessments • Well care office visits and associated x-ray and lab services • Development assessment of the child • Immunizations <ul style="list-style-type: none"> • H. Influenza type b • Influenza (flu shot) • Pneumococcal Conjugate (pneumonia) • Tetanus, Diphtheria, Pertussis (DTaP) • Measles, Mumps, Rubella (MMR) • Hepatitis A • Hepatitis B • Varicella (chicken pox) • Polio • Screening Services: <ul style="list-style-type: none"> • Vision • Hearing • Lead level 	100%	70%

Summary of Benefits	In-Network	Out-of-Network
<p>Preventive Services for Children over Age 5 and Adults (Eligible In-Network services not subject to the Deductible)</p> <p>Services include but are not limited to:</p> <ul style="list-style-type: none"> • Periodic Health Assessments • Physical exam • Well care office visits and associated x-ray and lab services • Immunizations <ul style="list-style-type: none"> • Influenza (flu shot) • Pneumococcal Conjugate (pneumonia) • Tetanus, Diphtheria (Td) • Measles, Mumps, Rubella (MMR) • Hepatitis A • Hepatitis B • Varicella (chicken pox) • Meningococcal • Meningococcal Polysaccharide • Rotavirus • Human Papilloma Virus (HPV) • Screening Services: <ul style="list-style-type: none"> • Colorectal cancer (fecal occult blood) • Colorectal cancer (flexible sigmoidoscopy) • Colorectal cancer (colonoscopy) • Colorectal cancer (air contrast barium enema) • Type II Diabetes (blood glucose test for high-risk individuals such as hypertension) • Cholesterol • Lipid • HIV testing • Screening Services for Males: <ul style="list-style-type: none"> • Prostate cancer (digital rectal examination) • Prostate cancer (prostate specific antigen) • Screening Services for Females <ul style="list-style-type: none"> • Breast exam • Osteoporosis (bone density) • Routine pelvic, pap test, and contraceptive management • Mammogram • Chlamydia Test (as part of routine pelvic exam) • Ovarian Surveillance 	100%	70% (Subject to Deductible)
Urgent Care Facility / Physician Services	100%	70%
<p>Maternity Services</p> <p>Includes Physician pre-and post-natal care and delivery</p>	100%	70%
<p>Physical Therapy / Occupational Therapy</p> <p>Percentage payable</p> <p>Maximum visits per calendar year, combined specialties (In- and Out-of-network combined)</p>	100%	70%
		20

Anthem Lumenos HSA

Summary of Benefits	In-Network	Out-of-Network
Speech Therapy Visits per calendar year (In-network and Out-of-network combined)	100%	70%
	20	
Chiropractic Care Visits per calendar year (In-network and Out-of-network combined)	100%	70%
	20	
Respiratory Therapy: Visits per calendar year (In-network and Out-of-network combined)	100%	70%
	30	
Radiation Treatment / Chemotherapy	100%	70%
Telemedicine / Teleradiology Services	100%	70%
Other Services		
Skilled Nursing Facility Days per calendar year (In-network and Out-of-network Combined)	100%	70%
	30	
Home Health Care Services Visits per calendar year (In-network and Out-of-network combined)	100%	70%
	120	
NOTE: Covered Services available under Home Health Care do not reduce outpatient therapy benefits available under the Physical, Occupational or Speech Therapy sections shown in this Contract.		
Hospice Care Services	100%	100%
Durable Medical Equipment (When Medically Necessary) Some items require pre-certification and/or prior approval.	100%	70%
Wigs (when Medically Necessary)	100%	70%
Benefit maximum every 12 months	\$500	
Prescription Drugs		
Retail – 30-day supply	80%	60%
Mail Order – 90-day supply	80%	60%
Note: A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a Prescription Drug requires pre-authorization, please call Customer Service.		
If a non-participating pharmacy is used, the Member must file a claim for reimbursement; the Member may be responsible for the difference between the Anthem negotiated rate and the pharmacy's actual charge.		
All Other Covered Medical Expenses	100%	70%

Verification of Benefits

Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Customer Service with a **benefits inquiry** or **Verification of Benefits** during normal business hours (7:30 a.m. to 7:00 p.m. eastern time). Please remember that a **benefits inquiry** or **Verification of Benefits** is **NOT** a Verification of Coverage of a specific medical procedure.

- **Verification of Benefits is NOT a guarantee of payment.**
- **If the verified service requires pre-certification, please call 1-800-722-6614.**

Pre-Admission Certification (PAC) Required

- Required for **ALL** Hospital admissions except emergency or maternity delivery admissions. Please notify us within 48 hours of an emergency or maternity admission.
- Pre-Admission Certification (PAC) determinations are available by phone through Anthem's pre-certification staff 24 hours a day, seven days a week for urgent/non-elective care that must be performed within 24 hours after the PAC request, without which a significant threat to the patient's health or well-being will be posed.
- Non-urgent/elective pre-certifications can be requested during normal business hours (7:30 a.m. – 7:00 p.m. eastern time).
- The phone number for pre-certification is **1-800-722-6614**.
- Emergency services do **NOT** require pre-certification.

PAC is a guarantee of payment as described in this section (and Anthem will pay up to the reimbursement level of this Contract when the Covered Services are performed within the time limits assigned by PAC) **except for the following situations:**

- The Member is no longer covered under this Contract at the time the services are received;
- The benefits under this Contract have been exhausted (examples of this include day limits or maximum amounts);
- No benefits will be paid in cases of fraud.

Pre-certification approvals apply only to services which have been approved in the pre-certification process and only as described in the approval. Such approval does not apply to any other services. Payment or authorization of such a service does not require or apply to payment of claims at a later date regardless of whether such later claims have the same, similar or related diagnoses.

Types of Coverage

Your type of coverage is determined by your selection at the time of enrollment through the Group.

Note: These benefits are valid for your Group's current Contract period. You will receive a revised Summary of Benefits if there is a change in your Group benefits.

Summary Notice

This Certificate Booklet summarizes your employer's health care benefit program. This Certificate Booklet is written in an easy-to-read language to help you and your Dependents understand your health care benefits. It is issued as part of your employer's Group Master Contract and governs your group's coverage.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate Booklet carefully. If you have any questions about your benefits as presented in this Certificate Booklet, please contact your employer's Employee benefits specialist or call our Customer Service Department.

This Certificate Booklet is an integral part of your employer's Group Master Contract. Its purpose is to help you understand your coverage and to provide an explanation of certain other benefits that your employer may offer. Certain administrative details and legal rights provisions are included in a separate document which is held by your employer.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción. *English translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number on the back of your ID card or in your enrollment booklet.*

A Member has direct access to primary and specialty care directly from any In-Network Physician.

Mental Health Care or Substance Abuse Treatment may be obtained by calling 1-800-292-2879.

A Member who seeks eye care may obtain such service directly from a BlueChoice Option ophthalmologist or optometrist who is licensed to provide eye care. Care is limited to medical conditions only, not routine vision care.

When You Are Away From Home

If you are away from the Service Area on business or pleasure, you still have coverage for Medical Emergencies. If you have a Medical Emergency, go to the nearest Hospital emergency room for treatment. If you are outside of the Service Area, you will have to pay for any treatment you receive. We will reimburse you except for any required Coinsurance or Out-of-Pocket amount. You will need a copy of any bills. Call Customer Service as soon as it's convenient and one of the representatives will tell you what you should do.

Should your treatment require you to be hospitalized, call the Customer Service Department or have someone call for you within 48 hours.

NOTICE: The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Important Phone Numbers and Websites

Pre-Admission Certification (PAC)

The Hospital, your Physician, or you should call:

- 1-800-722-6614

Outpatient Pre-certification

Your Physician or you should call the Utilization Management Department:

- 1-800-722-6614

Customer Service

If you have a customer service question, please call:

- 1-877-812-9777

Mental Health Care or Substance Abuse Treatment

You may access the mental health network in complete confidence by calling:

- 1-877-812-9777

360° Health

For discounts and health information, please log on to the Member Access page at:

- www.anthem.com

24/7 Nurseline

24/7 Nurseline provides telephonic counseling through a trained nurse care manager who encourages the cost-effective use of health care as well as promotes enrollment in other health and disease management programs.

- 1-866-800-8780

Special Phone Numbers

Please refer to your ID card for telephone numbers unique to your Group coverage.

Lifestyle Improvement & Healthy Rewards Incentive Programs

As a Member, you will receive an allocation for participating in and/or completing the programs described below. You may have to satisfy certain eligibility criteria before you can participate in these programs.

Our programs are free of charge and there is no requirement to join any club or membership of any kind. The programs are available online at our website, www.anthem.com or, if internet access is unavailable, you can still participate using hardcopy versions which can be obtained by calling the customer service number on your Identification Card.

- **Health Risk Assessment** – a \$50 reward opportunity
- **Personal Health Coach Program** – a \$100 reward opportunity for joining and an additional \$200 opportunity for graduating from the program
- **Tobacco Treatment Program** – a \$50 reward opportunity
- **Weight Management Program** – a \$50 reward opportunity

Health Risk Assessment

You will receive an incentive allocation as shown above upon the completion of an online health risk assessment or annual update through our select vendor. A health assessment may be completed by any and all family members, yet only one Member may earn incentive allocations for completing the health assessment in any one calendar year. A Member may update a previously-completed health assessment, through our select vendor and will be awarded the same incentive allocation in subsequent years. The health information you provide is strictly confidential.

Personal Health Coach Program Participation

You will receive an incentive allocation as shown above upon agreeing to participate in and qualifying for the Personal Health Coach Program. Any qualifying Member (Subscriber or Dependents) is eligible to enroll if you have a health condition that requires ongoing attention and therefore earn incentive allocations for Health Coach enrollment. Health conditions may include but are not limited to diabetes, asthma, depression, high blood pressure, heart disease and pregnancy. Call a Health Coach to receive a confidential consultation and learn about the program. A Health Coach will provide you with important health information, help you set health goals with your doctor and give you practical ideas to improve your health. There are no limits to the number of family Members who may enroll in Health Coach. Each family Member who enrolls will receive the incentive allocation shown above. A Member may only enroll and receive a Health Coach incentive allocation once per year. Members with multiple health conditions will be enrolled in one, holistic Health Coach Program. Members must remain 'qualified' and can enroll and graduate in the Health Coach program and earn incentive allocations in subsequent years.

Personal Health Coach Program Graduation

If you graduate by achieving your goals and successfully completing the program, you will receive an additional incentive allocation shown above. You successfully graduate from the program when you demonstrate that you have:

- Knowledge of your condition;
- Self-management skills;
- Ability to comply with the treatment plan;
- Achieved an effective relationship with a principle care Physician;
- Achieved clinical outcome goals (i.e. lowering your blood pressure, weight loss, etc.). If it is medically inadvisable or unreasonably difficult due to a medical condition to achieve the goals, as determined by your Physician, alternatives will be discussed.

Each Member is allowed only one Personal Health Coach Graduation Reward per Benefit Period.

Tobacco Treatment Program

The Tobacco Treatment Program helps participants through the “quit process” to manage withdrawal symptoms, identify triggers and learn new behaviors and skills to remain tobacco free. Nicotine Replacement Therapy (NRT), including gum and patches, is covered as a part of this program. Subscribers and their Dependents over age 18 may participate in this program if they meet certain eligibility criteria. In addition, eligible Subscriber and spouse may each receive an incentive allocation as shown above, upon completion of this program.

Weight Management Program

Our Weight Management Program is flexible, personalized phone course designed to help participants adopt lifestyle changes necessary to lose and maintain weight loss. Course participants work through the program with a team of counselors- a registered dietician and health educator- with expertise in weight management and behavior change. Subscribers and their Dependents over age 18 with a BMI of 25 or greater are eligible for the program. Additionally, the Subscriber and spouse may each receive an incentive allocation as shown above, upon completion of this program.

About Health Savings Accounts

This high Deductible policy is designed to be a federally qualified High Deductible Health Plan (HDHP) compatible with Health Savings Accounts. This contract may qualify you to make a pre-tax annual contribution to a Health Savings Account (HSA). NOTICE: Anthem does NOT provide tax advice. The Georgia Insurance Department does NOT in any way warrant that this policy meets the federal requirements.

The high Deductible Plan is not a “health savings account” or an “HSA,” but is designed as an “HSA compatible high Deductible health Plan” that may allow you, if you are an eligible individual, to take advantage of the income tax benefits available to you when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the Deductible under this Contract.

NOTICE: Anthem does not provide tax advice. If you intend to purchase this Contract to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements.

Anthem has designed this Contract to meet government requirements for an HSA compatible high Deductible health Contract to be used in conjunction with establishing eligibility for HSA tax benefits. Although Anthem believes that the Contract meets these requirements, the Internal Revenue Service has not ruled on whether the Contract is qualified as an HSA compatible high Deductible health Contract.

Should you purchase this Contract in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this Contract does not qualify as a high Deductible health Contract, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible.

Eligibility

For Out-of-Network services, this health program contains a 12-month pre-existing condition waiting period except for maternity benefits. For Out-of-Network services, if a Member enrolls within 31 days of being eligible and has 12 months of prior Creditable Coverage with no significant break in coverage, the pre-existing condition waiting period will not apply. Members who do not enroll within 31 days of being eligible are considered Late Enrollees. Please refer to the “Late Enrollees” provision in this section.

Coverage for You

This booklet describes the benefits you may receive under your health care program. You are called the Subscriber or Member.

Coverage for Your Dependents

If you're covered by this program, you may enroll your eligible Dependents. Your Covered Dependents are also called Members.

If the wrong birthdate of a child is entered on an application, the child has no coverage for the period for which he or she is not legally eligible. Any overpayments made for coverage for any child under these conditions will be refunded by either you or Anthem.

Your Eligible Dependents Include:

- Your wife or husband (spouse);
- Your unmarried Dependent children until attaining age 19, legally adopted children from the date you assume legal responsibility, children for whom you assume legal guardianship and stepchildren. Also included are your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree. Children may be covered up to and including age 25 provided they remain your Dependents and, in each calendar year since reaching age 19, are enrolled as full-time students in a post-secondary institution of higher learning for five calendar months or more. Children up to and including age 25 that were required to withdraw enrollment from a post-secondary institution, prevented from enrollment, or required to reduce enrollment below the level required for full-time status as a result of an injury or illness shall be entitled to the same benefits as if the Dependent continued to be enrolled as a full-time student.
- Unmarried children who are mentally or physically handicapped and totally dependent on you for support, regardless of age, with the exception of incapacitated children age 19 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Contract or prior Creditable Coverage prior to reaching age 19. Certification of the handicap is required within 31 days of attainment of age 19. A certification form is available from your employer or from Anthem and may be required periodically but not more frequently than annually after the two year period following the child's attainment of the limiting age.

Please note: For the purpose of this Contract, a spouse is the Subscriber's legal spouse as recognized by the state in which you live.

Initial Enrollees

Initial Enrollees and eligible Dependents who were previously enrolled under group coverage which this Contract replaces are eligible for coverage on the Effective Date of this coverage. Any employer or pre-existing exclusion waiting periods which were not satisfied under previous Creditable Coverage must be satisfied under this Contract. However, credit will be given for the length of time already served.

New Hires

Applications for enrollment must be submitted within 31 days from the date you are eligible to enroll as set by the employer. Applications for membership may be obtained from your employer. Your coverage will be effective based on the waiting period chosen by your employer. If you or your Dependents do not enroll when first eligible, you will be treated as a Late Enrollee. Please refer to the “**Late Enrollees**” provision listed below.

Late Enrollees

If you or your Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, you may be eligible for special enrollment as set out below.

Special Enrollment Periods

There are special enrollment periods for Employees or Dependents who:

- Originally declined coverage because of other coverage, and
- Exhausted COBRA benefits, lost eligibility for prior coverage, or employer contributions toward coverage were terminated.

An individual who declined coverage must certify in writing that he or she was covered by another health program when he or she initially declined coverage under this Group in order to later qualify under this special enrollment. Persons declining coverage will be given notice of the consequences when they originally decline coverage.

In addition, there are also special enrollment periods for new Dependents resulting from marriages, births or adoptions. If a birth or adoption occurs and the new Dependent is enrolled within 31 days of the birth or adoption, then no twelve (12) month pre-existing condition waiting period will apply. An unenrolled Member may enroll within 31 days of such a special qualifying event.

Important Notes:

- Individuals enrolled during special enrollment periods are **not** Late Enrollees and are subject to the normal 12-month pre-existing condition requirements unless enrolled under prior Creditable Coverage (excluding newborns, adoptions and pregnancies).
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).
- Evidence of prior Creditable Coverage is required and must be furnished by you or your prior carrier.

Medicaid and CHIP Special Enrollment/Special Enrollees

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

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

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Your Coverage Begins

If you apply when first eligible, your coverage will be effective on the date your Group’s length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision your employer requires; however, you will receive credit toward your pre-existing condition waiting period for any employee length-of-service requirement which you must serve.

Changing Your Coverage

There may be an annual re-enrollment period during which time Members may elect to change their options. Employees and Dependents enrolled in another option may be required to complete an unfulfilled waiting period from prior Creditable Coverage.

Changing Your Coverage (Adding a Dependent)

You may add new Dependents to your Plan by contacting your Plan Administrator. You or the Plan Administrator must notify Anthem in writing. The Plan Administrator is the person named by your Employer to manage the program and answer questions about program details.

Coverage is provided only for those Dependents you have reported to Anthem and added to your coverage by completing the correct application.

Your premiums may increase due to marriage, birth, or adoption.

Marriage and Stepchildren

A Member may add a spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage.

If a Member does not apply for coverage to add a spouse and stepchildren within 31 days of the date of marriage, the spouse and stepchildren are considered Late Enrollees. Please refer to the “**Late Enrollees**” provision in this section.

Newborn and Adopted Children

A newborn or an adopted child is covered automatically for 31 days from the moment of birth or date of assumption of legal responsibility up to age 19. If additional Premium is required to continue coverage beyond the 31-day period, the Member must notify Anthem of the birth or adoption and pay the required Premium within the 31-day period or coverage will terminate. Types of coverage requiring additional Premium include one-person coverage and two-person coverage.

If a Member has family coverage or multi-person coverage, no additional Premium is required and coverage automatically continues. However, the Member should notify Anthem of the birth or adoption within 31 days to ensure accurate records and timely payment of claims.

Extending coverage for a newborn child or an adopted child being added to one-person or two-person coverage beyond the 31-day period requires late enrollment. Please refer to the “**Late Enrollees**” provision in this section.

Foster Children

Foster children are children of those whose parental rights have been terminated by the state and who have been placed in an alternative living situation by the state. A child does not become a foster child when the parents voluntarily relinquish parental power to a third party.

Foster children for whom a Member assumes legal responsibility are not covered automatically. In order for a foster child to have coverage, a Member must provide confirmation of a valid foster parent relationship to Anthem. Such confirmation must be furnished at the Member's expense. When the application is processed, the Effective Date will be the first of the month following your Group's Employee waiting period.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:

- An adopted child, regardless of whether or not the adoption has become final. Pre-existing condition limitations will not apply to the child as long as the adoption (or placement for adoption) occurs while the Employee is eligible for coverage.
 - An “adopted child” is any person under the age of 18 as of the date of adoption or placement for adoption. “Placement for adoption” means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- A child for whom an Employee has received a MCSO (a “Medical Child Support Order”) which has been determined by the employer or Plan Administrator to be a Qualified Medical Child Support Order (“QMCSO”).
 - Upon receipt of an MCSO, the employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the employer to provide any type or form of benefit that it is not already offering.

Family and Medical Leave

For groups with 50 or more Employees, if a covered Employee ceases active employment due to an employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Changing Your Coverage or Removing a Dependent

When any of the following events occur, notify your employer and ask for appropriate forms to complete:

- Divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Dependent child reaches age 19 or marries (see “When Your Coverage Terminates”);
- Enrolled Dependent child becomes totally or permanently disabled.

Employee Not Actively at Work

- **Initial Enrollees**

After a group takeover, if a Member (or a Dependent) had coverage under a prior carrier and is now covered under an extension of benefits provision, the Member (or Dependent) will be enrolled for coverage under this Contract. However, the prior carrier’s extension of benefits provision makes the prior carrier responsible for payment of benefits and services relating to disabilities in accordance with the terms of its coverage and state law. To the extent benefits and services are not covered by the prior carrier’s extension of benefits provision, payment will be made under this Contract in accordance with the ordinary Contract rules covering such benefits and services.

- **New Hires**

Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Group but not currently active due to health status.

Portability Provision

Any newly eligible Employee, Member, Subscriber, enrollee or Dependent who has had similar coverage under another health benefit plan within the previous 90 days is eligible for coverage immediately. The Effective Date of coverage is subject to any length-of-service provision your employer requires. A newly eligible person is an individual who was not previously eligible for coverage under this Group Contract.

There is a 12-month pre-existing condition waiting period for Out-of-Network benefits imposed following the Effective Date of Coverage; however, this period is waived to the extent that an individual had prior Creditable Coverage.

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will automatically receive a certification showing when you were covered under the Plan. You may need the document to qualify for another group health plan. You may also need the certification to buy, for yourself or your family, an individual policy that does not exclude coverage for medical conditions that were present before your enrollment. Certification may be requested within 24 month of losing coverage. If you have any questions, contact customer service at the telephone number listed on the back of your Identification Card.

How Your Benefits Work For You

Note: Capitalized terms such as Covered Services, Medical Necessity, Network Hospitals and Out-of-Pocket Limit are defined in the Definitions section.

Introduction

Lumenos Open Access POS is a comprehensive plan that provides Physician and Specialist health care services. **All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.** A Member has direct access to primary and specialty care directly from any In-Network Physician.

Physicians and Hospitals participating in our Networks are compensated using a variety of payment arrangements, including capitation, fee for service, per diem, discounted fees, and global reimbursement.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

BlueChoice Option / Lumenos Open Access POS Benefits

BlueChoice Option is a comprehensive benefit plan called "Point-of-Service." This means that you have a choice when you go to a Physician, Hospital or other provider of health care. The Contract is divided into two sets of benefits: In-network and Out-of-network. If you choose In-network benefits, you are directed to any necessary services through your Physician who coordinates your health care. If you choose Out-of-network benefits, you will pay more. Each time you visit a provider, you will have that choice to make. That's why it's called Point-of-Service.

Consumer Choice Option – (Please note the following applies only if you purchased the Consumer Choice Option at enrollment)

The Consumer Choice Option allows you to nominate an Out-of-Network Provider (limited to a Physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advance practice nurse, registered optician, licensed professional counselor, physical therapist, licensed marriage and family therapist, chiropractor, qualified athletic trainer (per OCGA 43-5-8), occupational therapist, speech language pathologist, audiologist, dietitian, Physician's assistant or Hospital) for specified Covered Services. Such nominated providers must be approved in writing by Anthem, and are subject to the normal rules and conditions which apply to a contracted Network Provider. These terms include reimbursement (who we pay and how much), utilization management protocols (pre-certification procedures and our internal procedures enabling us to pay for Covered Services), Prescription Drug Formulary compliance (making sure we pay for drugs on our approved list), Referral to Network or Non-Network Providers, and other internal procedures which Anthem normally follows. All Non-Network Providers must be nominated, agree to participate and be approved.

Please remember that, while you may obtain benefits at In-Network levels from an approved, nominated provider, these providers have not gone through Anthem's rigorous credentialing process, and they are not subject to Anthem's quality assurance standards.

The nominated provider is not an In-Network Provider and has not been credentialed by Anthem. The Member alone is responsible for the selection of the nominated provider and Anthem has not undertaken any credentialing or quality assurance measures regarding such nominated provider. Anthem will not undertake to conduct routine quality assurance measures which are used for In-Network Providers. The Member should understand that any and all Physicians, Hospitals and any others who are not In-Network Providers must be nominated by the Member (patient) and approved by Anthem prior to any services being performed by the provider in order for the services to become eligible for reimbursement at In-Network benefit levels. For additional information, please contact your Plan Administrator.

Provider Nomination

Under the Consumer Choice Option, you may nominate any Hospital or provider listed above licensed to practice in the state of Georgia to render specified Covered Services. However, you do **not** have free unrestricted access to non-nominated providers or to providers who have been nominated by you but not yet approved by Anthem.

The nomination process includes several steps:

- You may obtain copies of the nomination form by calling 1-877-812-9777.
- Complete and sign the first section of the nomination form and give to your provider.
- The provider signs the second part of the form, indicating they may be interested in acting as your provider, subject to Anthem's terms and conditions. The provider requests authorization for specific procedures (or ongoing medical treatment). The provider submits the form to Anthem.
- Anthem verifies the licensure of the provider and notifies the provider of the applicable fee schedule or potential reimbursement.
- The provider, after receiving the notice of the potential reimbursement, signs and returns the form to Anthem.
- Anthem notifies you and your provider if and when the fully completed form has been received and approved.

A decision will be made by Anthem within 3 days of the receipt of the fully completed nomination form. Please note that approval is made only for the requested procedures. Additional procedures must be requested and approved by us.

It is important to remember that only after all these steps and all other Contract requirements have been followed are Covered Services paid when provided by a Non-Network Provider.

What Your Program Pays

The Calendar Year Deductible

Before your program begins to pay benefits, you must meet any **Deductible** required. Deductible requirements are stated in the **Summary of Benefits**.

Coinsurance and Out-of-Pocket Limit

The percentage payable by Anthem is stated in the **Summary of Benefits**. The portion which you must pay (the **Coinsurance**) is stated in the **Summary of Benefits**. After you reach your **Out-of-Pocket Limit**, your Contract pays 100% of Eligible Charges for the remainder of the calendar year.

See the Summary of Benefits to determine if you have a Coinsurance Amount and an Out-of-Pocket Limit.

Eligible Charges

For In-Network services, Eligible Charges are determined by: (a) Anthem's negotiated arrangements; (b) pre-determined fee schedules; and (c) the applicable Reimbursement Rate. For Out-of-Network services, Eligible Charges are determined by: (a) Anthem's Usual, Custom and Reasonable (UCR) Fees; (b) a provider's contracted fee schedule; (c) the applicable Reimbursement Rate; or (d) negotiated fees. Reimbursement for Out-of-Network and Participating Providers is based on Eligible Charges for the type of service a Member receives (for example, Hospital or Physician services.) Reimbursement for Non-Contracted Providers is determined by our Default Reimbursement Rate.

Out-of-Pocket Limits are accumulated for In-network and Out-of-network Providers as shown in the **Summary of Benefits**.

Lifetime Maximum Benefit

Any eligible Member is covered under the Group Contract to a total Lifetime Maximum Benefit as stated in the **Summary of Benefits**. This total amount of coverage includes certain services which have smaller lifetime maximums that are included within the total Lifetime Maximum Benefit. These maximums are also stated in the **Summary of Benefits**.

The Lifetime Maximum Benefit outlined in the **Summary of Benefits** includes all payments made under this Contract with Anthem or its affiliates.

All services and all calendar year maximums—whether for a number of days or visits, treatments or a yearly dollar limit—are subject to the Lifetime Maximum Benefit.

Pre-Admission Certification (PAC) and Outpatient Pre-Certification

Hospital Pre-certification

The Pre-Admission Certification Process

- Length-of-Stay Assignment indicates the number of Inpatient days usually Medically Necessary to treat a condition;
- Continued Stay Review/Concurrent Review determines whether a continued Inpatient stay is Medically Necessary. If your stay exceeds the number of days assigned under this program, the Hospital's charge for additional days beyond the assigned length of stay will not be paid. If all Physician or Specialist guidelines are followed, you will not be responsible for any Eligible Hospital charge in excess of any applicable Coinsurance amount. If you receive Out-of-network Care, you will be responsible for the Hospital's charges;
- Admission Review determines whether an unscheduled Inpatient admission or an admission not subject to pre-certification was Medically Necessary;
- Discharge Planning assesses the Member's need for additional treatment after Hospital discharge.

In-Network Care

- If you are hospitalized other than in an emergency or for a maternity delivery admission and Pre-Admission Certification was not obtained, all charges will be denied. You will be held harmless if all Network guidelines are followed. This means you will not be responsible for any bill in excess of the Coinsurance that applies.
- Ineligible Charges and Non-Covered Services are always the Member's responsibility.
- PAC is the responsibility of the admitting Physician.

Out-of-Network Care

- You, the Physician or the Hospital **must** obtain approval for all Hospital admissions.
- If you are hospitalized other than in an emergency or for a maternity delivery admission and Pre-Admission Certification was not obtained, all charges will be denied. You—the Member—will be responsible for the Hospital's charges in addition to any Deductible, Coinsurance and Ineligible Charges.
- If you obtained PAC but exceed the number of days allowed through the PAC process, you will be responsible for the charges for those days.
- If you are admitted to a Hospital and the admission is determined not to be Medically Necessary, all charges for that admission and related Physician charges will be Ineligible Charges. Out-of-Network Providers are under no obligation to hold you harmless for those charges, so you may be responsible for the full amount of all of those charges.
- Ineligible Charges are always the Member's responsibility.

Pre-Admission Certification is a guarantee of payment

Admissions are approved only when the appropriateness of the Inpatient setting can be substantiated. Actual payment is based upon eligibility for coverage and the Effective Date for any Member and also will be dependent on, but not limited to, specific Group coverage and the status of the coverage on the date services are rendered. The Contract will not cover services related to specific Contract exclusions and limitations, including but not limited to, Custodial Care, Experimental or Investigational procedures, pre-existing conditions during the waiting period and services determined not Medically Necessary.

Outpatient Pre-certification Requirements

Outpatient pre-certification is a requirement for both In-Network and Out-of Network benefits. Your Contract provides Covered Services when outpatient services are Medically Necessary. Certain outpatient procedures require pre-certification from Anthem. Such services include, but are not limited to, outpatient surgical procedures, diagnostic imaging procedures, laboratory services, and Durable Medical Equipment.

In-Network Care

- If you receive treatment and pre-certification was not obtained, or the treatment is determined not to be Medically Necessary, all charges will be Ineligible Charges. You – the Member – will be held harmless if all Network guidelines are followed and services were performed by a Network Provider. This means you will not be responsible for any bill in excess of the related Coinsurance amount.
- Charges for Non-Covered Services are always the Member's responsibility.
- Pre-certification is the responsibility of the Network Physician.

Out-of-Network Care

- You, the Physician or the Hospital **must** obtain approval for all procedures listed above.
- If you receive treatment and pre-certification was not obtained, all charges will be Ineligible Charges. You—the Member—will be responsible for all such Out-of-Network charges.
- If you receive treatment and the procedure is determined not to be Medically Necessary, all charges for that procedure will be Ineligible Charges. Out-of-Network Providers are under no obligation to hold you harmless for those charges, so you may be responsible for the full amount of all of those charges.

Pre-certification is required for the following outpatient procedures:

- Arthroscopy – shoulder & knee
- CT
- CTA
- Echocardiography (if not ordered by a Cardiologist)
- Home Health Care
- Hysterectomy (under age 35)
- MRA
- MRI
- Nuclear Cardiology
- Orthognathic/TMJ
- PET
- Reconstructive Surgery
- Sleep Studies
- Transplant Evaluations – Call (866) 694-0724 or fax (888) 896-8679
- UPPP

(This list is subject to change.)

If you have any questions regarding these pre-certification requirements, please contact Customer Service at the number listed on your ID card.

Benefits

All Covered Services must be Medically Necessary, whether provided through In-Network Providers or Out-of-Network Providers.

Allergy Conditions

Benefits are provided as stated in the **Summary of Benefits**.

Ambulance Service

Local service to the nearest appropriate facility in connection with care for a Medical Emergency or if otherwise Medically Necessary. Such service also covers your transfer from one Hospital to another if Medically Necessary. Air ambulance to the nearest appropriate facility is covered subject to Medical Necessity.

Anesthesia Services for Certain Dental Patients

Pre-certification is required. General anesthesia and associated Hospital or ambulatory surgical facility charges are covered in conjunction with dental care provided to the following:

- Patients age 7 or younger or developmentally disabled.
- An individual for whom a successful result cannot be expected by local anesthesia due to neurological disorder.
- An individual who has sustained extensive facial or dental trauma, except for a Workers' Compensation claim.

Assistant Surgery

If Medically Necessary, services rendered by an assistant surgeon are covered in conjunction with a surgery which has been coordinated by the Member's surgeon or for Out-of-Network Care which has been pre-certified by Anthem.

Attention Deficit Disorder (Medical Treatment of)

Pre-certification is required. Only legend Prescription Drugs will be covered.

Breast Cancer Patient Care

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

Breast Reconstructive Surgery

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Cardiac Rehabilitation

Programs require prior authorization and individual case management.

Chiropractic Care

Covered Services for In-Network Spinal Manipulation are available **only** if stated in the **Summary of Benefits**.

Clinical Trial Programs for Treatment of Children's Cancer

Covered Services include routine patient care costs incurred in connection with the provision of goods, services, and benefits to Members who are Dependent children in connection with approved clinical trial programs for the treatment of children's cancer. "Routine patient care costs" means those pre-certified as Medically Necessary costs as provided in Georgia law (OCGA 33-24-59.1)

Colorectal Cancer Examinations and Laboratory Tests

Covered Services include colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines for colorectal cancer screening. Benefits shall be provided for Members who are 50 years of age or older and less than 50 years of age and at high risk for colorectal cancer according to the current colorectal cancer screening guidelines of the American Cancer Society.

Complications of Pregnancy

Benefits are provided for Complications of Pregnancy (see "Definitions") resulting from conditions requiring Hospital confinement when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

Benefits for a normal or difficult delivery are not covered under this provision. Such benefits are determined solely by the maternity section of this Contract.

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury.

Diabetes

Equipment, supplies, pharmacological agents, and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

Dialysis Treatment

Dialysis treatment is covered if care has been pre-certified by and coordinated through your Physician. If services are rendered Out-of-Network, dialysis treatment is covered when pre-certification has been obtained from Anthem. We will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

Durable Medical Equipment

This program will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity and applicable pre-certification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. We may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the patient's physical disorder.

Emergency Room Care

Coverage is provided for Hospital emergency room care for initial services rendered for the onset of symptoms for a Medical Emergency or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or cause serious harm.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure that is a Covered Service. Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are also covered.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- Spinal or regional anesthesia;
- Injection or inhalation of a drug or other agent (local infiltration is excluded).

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Summary of Benefits**. A visit consists up to 4 hours of care. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Contract.
- A Member must be essentially confined at home.

Covered Services:

- Visits by an RN or LPN-Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health do **not** include:

- Food, housing, homemaker services, sitters, home-delivered meals;
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care plan as described.
- Services of a person who ordinarily resides in the patient's home or is a member of the family of either the patient or patient's spouse.
- Any services for any period during which the Member is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the patient.
- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.

- Dietitian services.
- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.
- Private duty nursing care.

Hospice Care Services

Hospice benefits cover Inpatient and outpatient services for patients certified by a Physician as terminally ill with a life expectancy of six months or less.

Your Contract provides Covered Services for Inpatient and outpatient Hospice care as stated in the **Summary of Benefits**. The Hospice treatment program must:

- Be recognized as an approved Hospice program by Anthem;
- Include support services to help covered family members deal with the patient's death; and
- Be directed by a Physician and coordinated by an RN with a treatment plan that:
 - provides an organized system of home care;
 - uses a Hospice team; and
 - has around-the-clock care available.

The following conditions apply:

- To qualify for Hospice care, the attending Physician must certify that the patient is not expected to live more than six months.
- The Physician must design and recommend a Hospice Care Program; and
- The Physician's statement and recommended program should be pre-certified.

Hospital Services

For In-network Care, your Physician must arrange your admission. Your Contract provides Covered Services when the following services are Medically Necessary.

Inpatient

Inpatient Hospital Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If you stay in a private room, Eligible Charges are based on the Hospital's prevalent semiprivate rate. If you are admitted to a Hospital that has only private rooms, Eligible Charges are based on the Hospital's prevalent room rate. Pre-certification is required for all Hospital admissions.

Services and Supplies

- Services and supplies provided and billed by the Hospital while you are an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Outpatient

Outpatient Services

- Your Contract provides Covered Services when the following outpatient services are Medically Necessary: Pre-admission tests, surgery, diagnostic x-rays and laboratory services. Certain procedures require pre-certification.

Medical Emergency Care

- Care or treatment for a Medical Emergency is covered on a 24-hour basis at any Hospital emergency room. Go to the nearest Hospital emergency room if you experience a life-threatening Medical Emergency. See "Definitions".
- Physician notification, if not completed prior to emergency room visit, should occur within 48 hours of seeking emergency room care.
- Use of the emergency room for conditions that are not Medical Emergencies is **not** covered.
- Covered Services for Medical Emergencies include Medically Necessary mental health emergency care provided in the emergency room. This service is not limited by the twenty (20) outpatient In-network visit limitation. Emergency care coverage includes care related to Medical Emergencies associated with substance abuse.
- Follow-up care must be coordinated by your Physician if you choose the high level of benefits of In-network care.

Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each Physician during the covered period of confinement.

Individual Case Management

The individual case management program is designed to ensure and provide payment of benefits to eligible Members who, with their attending Physician, agree to treatment under an alternative benefit plan intended to provide quality health care under lower cost alternatives. Such benefits will be determined on a case-by-case basis, and payment will be made only as agreed to under a written alternative benefit plan for each program participant.

The program includes:

- the identification of potential program participants through active case finding and referral mechanisms;
- eligibility screening;
- preparation of alternative benefit plans;
- subsequent to the approval of the parties, transfer to alternative treatment settings in which quality care will be provided.

Eligibility

A Member receiving benefits under an alternative benefit plan may, at any time, elect to discontinue the plan and revert to regular Contract benefits.

Anthem is responsible for determining eligibility for cases to be included in the program.

The Member—or legal guardian or family member, if applicable—and the attending Physician must consent to explore with Anthem the possibilities of transfer to an alternative treatment setting and, prior to implementation, agree to the alternative benefit plan.

Anthem Lumenos HSA

Benefits

Benefits will be determined on a case-specific basis, depending on the plan of treatment, and may include Covered Services under the applicable Contract.

Services will be covered and payable as long as the treatment is required as outlined in the alternative benefit plan, and is less expensive than the original treatment plan which otherwise would have been followed. Anthem will determine the maximum approved payments allowable under the program.

Benefits under the program are furnished as an alternative to other Contract benefits and are limited to the following:

- Services, equipment and supplies which are approved as Medically Necessary for the treatment and care of the Member.
- Non-structural modifications to the home which are required to meet minimum standards for safe operation of equipment.
- When necessary for the long term care of the Member in the home-setting, Respite Care to relieve family members or other persons caring for the Member at home. (The Respite Care benefit can be credited at a rate of 24 hours for every month of care rendered in the home setting, and may be reimbursed for up to 6 consecutive days at a time. Anthem may approve on an exception basis up to 5 days per month of Respite Care when medical review of the case indicates that such action is appropriate. Payments for Respite Care will be deducted from the Member's remaining available benefits under the program.)

The Member must obtain pre-certification from Anthem regarding the treatment plan and proposed setting to be utilized during the Respite Care period.

Potential cases include but are not limited to:

- spinal cord Injury;
- severe head trauma/coma;
- respiratory dependence;
- degenerative muscular/neurological disorders;
- long term IV antibiotics;
- premature birth;
- burns;
- cardiovascular accident;
- cancer;
- accidents;
- terminal illnesses;
- other cases at Anthem's discretion.

Covered Services

- Services covered under individual case management will be determined by Anthem, at its sole discretion on a case-by-case basis. Benefits may be provided for the rehabilitation of a Member on an Inpatient, outpatient, or out-of-hospital basis, as long as they are Medically Necessary, support the plan of treatment, and ensure quality of care.
- The program may provide or coordinate any of the types of Covered Services provided pursuant to this Certificate Booklet.
- At its sole discretion, in the context of an individual case management program, Anthem may also provide or arrange for alternative services or extra-contractual benefits which are either (i) excluded by this Certificate Booklet; (ii) neither excluded nor defined as Covered Services under this Certificate Booklet; or (iii) exceeding the maximum for any Covered Service under this Certificate Booklet.

Utilization

- Benefits will be provided only when and for as long as Anthem deems they are Medically Necessary. The approved alternative benefit plan of treatment will establish which benefits will be provided and

for how long, and shall be subject to pre-certification and continuing review for Medical Necessity as set forth in such plan for treatment.

- The total benefits paid under this program will not exceed those which the Member would otherwise have received in the absence of individual case management benefits.

Exclusions

- Rehabilitation or Custodial Care for chronic (recurring) conditions that do not, in Anthem's sole discretion, significantly improve in an observable way within a reasonable period of time will not be a covered benefit under the individual case management program.

Individual Case Management Definitions

Case Manager

The person designated by Anthem to manage and coordinate the Member's medical benefits under the individual case management program. The Case Manager's role is determined by Anthem.

Provider

A Provider may be any facility or practitioner, including but not limited to Ineligible Providers, licensed or certified to give services or supplies consistent with the Plan of Treatment and approved by Anthem.

Termination of Individual Case Management

Services in the alternative benefit plan approved by Anthem under individual case management will cease to be Covered Services under this Contract when:

- Extra-contractual benefits or alternative services are no longer Medically Necessary, as determined by Anthem due to a change in the patient's condition, or
- The total amount of benefits paid for such services and for all other Covered Services equals the Lifetime Maximum Benefit.

Licensed Mid-Level Providers

Benefits are also payable for Covered Services provided by licensed mid-level providers. Such providers include, but are not limited to, Nurse Practitioners (NP), Physician Assistant (PA), and Physician Assistant Anesthetists (PAA).

Licensed Speech Therapist Services

The visits must be pre-certified by Anthem. Services must be ordered and supervised by a Physician and limited as shown in the **Summary of Benefits**. Developmental Delay will be covered when it is more than two standard deviations from the norm as defined by standardized, validated developmental screening tests such as the Denver Developmental Screening Test. Services will be covered only to treat or promote recovery of the specified functional deficits identified.

Maternity Care

Covered Services are provided for In-Network Maternity Care as stated in the **Summary of Benefits**.

Maternity benefits are provided for a female Employee and any eligible female Dependent.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing Your Coverage" to add a newborn to your coverage.)

Under federal law, the Contract may not restrict the length of stay to less than the 48/96-hour periods or require pre-certification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours

following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48- or 96-hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the Member's attending Physician.

Benefits are also payable for prenatal care, delivery services and postnatal care rendered by a Certified Nurse Midwife (CNM).

Medical and Surgical Care

General care and treatment of illness or Injury, and surgical diagnostic procedures including the usual pre- and post-operative care.

Non-Contracted Freestanding Ambulatory Facility

Any services rendered or supplies provided while you are a patient or receive services at or from a Non-Contracted Freestanding Ambulatory Facility will be payable at 50% of the Default Reimbursement Rate.

Nutritional Counseling

Nutritional counseling related to the medical management of a disease state (subject to pre-certification by Anthem).

Nutritional Counseling for Obesity

Covered Services for obesity include up to two nutritional counseling visits when referred by your Physician. Prescription drugs and any other services or supplies for the treatment of obesity are not covered.

Optometrist's Services

Services within the lawful scope of practice of and rendered personally by a licensed optometrist (O.D.), for which payment would be made under this Contract to a Physician providing the same services.

Oral Surgery

Pre-certification is required. To obtain the highest level of benefits, the Member must obtain pre-certification from a Network Physician. Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Treatment of Temporomandibular Joint Syndrome (TMJ) or myofascial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures). TMJ is subject to a Lifetime Maximum Benefit per Member as stated in the **Summary of Benefits**;
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure.

Organ/Tissue/Bone Marrow Transplant

Covered Services include certain services and supplies not otherwise excluded in this Certificate Booklet and rendered in association with a covered transplant, including pre-transplant procedures such as organ harvesting (Donor Costs), post-operative care (including antirejection drug treatment, if Prescription Drugs are covered under the Contract) and transplant related chemotherapy for cancer limited as follows.

A transplant means a procedure or series of procedures by which an organ or tissue is either:

- removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient); or
- removed from and replaced in the same person's body (called a self-donor).

A covered transplant means a Medically Appropriate transplant.

- Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.
- Autologous (self-donor) bone marrow transplants with high-dose chemotherapy is considered eligible for coverage on a prior approval basis, but **only** if required in the treatment of:
 - Non-Hodgkin's lymphoma, intermediate or high grade Stage III or IVB;
 - Hodgkin's disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB;
 - Neuroblastoma, Stage III or Stage IV;
 - Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have an HLA-compatible donor available for allogenic bone marrow support;
 - Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard dose chemotherapy, with FDA-approved platinum compounds;
 - Metastatic breast cancer that (a) has not been previously treated with systemic therapy, (b) is currently responsive to primary systemic therapy, or (c) has relapsed following response to first-line treatment;
 - Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a complete or partial remission, or those in a responsive relapse.
- Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment of:
 - aplastic anemia;
 - acute leukemia;
 - severe combined immunodeficiency **exclusive** of acquired immune deficiency syndrome (AIDS);
 - infantile malignant osteoporosis;
 - chronic myelogenous leukemia;
 - lymphoma (Wiscott-Aldrich syndrome);
 - lysosomal storage disorder;
 - myelodysplastic syndrome.

"Donor Costs" means all costs, direct and indirect (including program administration costs), incurred in connection with:

- medical services required to remove the organ or tissue from either the donor's or the self-donor's body;
- preserving it; and
- transporting it to the site where the transplant is performed.

In treatment of cancer, the term "transplant" includes any chemotherapy and related courses of treatment which the transplant supports.

For purposes of this benefit, the term transplant does not include transplant of blood or blood derivatives (except hematopoietic stem cells) which will be considered as nontransplant related under the terms of the Contract.

"Facility Transplant" means all Medically Necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and antirejection drugs.

"Medically Necessary" means the recipient or self-donor meets the criteria for a transplant established by Anthem.

"Professional Provider Transplant Services" means all Medically Necessary services and supplies provided by a professional provider in connection with a covered transplant except Donor Costs and antirejection drugs.

Benefits for Antirejection Drugs

For antirejection drugs following the covered transplant, Anthem will pay according to the benefits for Prescription Drugs, if any, under the Contract.

Pre-certification Requirement

All transplant procedures must be pre-certified for type of transplant and be medically appropriate according to criteria established by Anthem. To pre-certify, call the Anthem office using the telephone number on your Identification Card.

The pre-certification requirements are a part of the benefit administration of the Contract and are not a treatment recommendation. The actual course of medical treatment the Member chooses remains strictly a matter between the Member and his or her Physician.

Your Physician must submit a complete medical history, including current diagnosis and name of the surgeon who will perform the transplant. The surgery must be performed at a recognized transplant center. The donor, donor recipient and the transplant surgery must meet required medical selection criteria as defined by Anthem.

If the transplant involves a living donor, benefits are as follows:

- If a Member receives a transplant and the donor is also covered under this Contract, payment for the Member and the donor will be made under each individual's coverage.
- If the donor is not covered under this Contract, payment for the Member and the donor will be made under this Contract but will be limited by any payment which might be made under any other hospitalization coverage plan.
- If the Member is the donor and the recipient is not covered under this Contract, payment for the Member will be made under this Contract limited by any payment which might be made by the recipient's hospitalization coverage with another company. No payment will be made under this Contract for the recipient.

Please see the "Limitations and Exclusions" section for Non-Covered Services.

Osteoporosis

Benefits will be provided for qualified individuals for reimbursement for scientifically proven bone mass measurement (bone density testing) for the prevention, diagnosis and treatment of osteoporosis for Members meeting Anthem criteria.

Other Covered Services

Your Contract Provides Covered Services when the following services are Medically Necessary:

- Use of operating and treatment rooms and equipment
- Diagnostic x-ray and laboratory procedures
- Chemotherapy and radioisotope, radiation and nuclear medicine therapy
- Oxygen, blood and components, and administration
- Dressings, splints, casts when provided by a physician
- Pacemakers and electrodes

Ovarian Cancer Surveillance Tests

- Covered Services are provided for at risk women 35 years of age and older. At risk women are defined as: (a) having a family history (i) with one or more first or second-degree relatives with ovarian cancer, (ii) of clusters of women relatives with breast cancer, (iii) of nonpolyposis colorectal cancer; or (b) testing positive for BRCA1 or BRCA2 mutations.
- Surveillance tests mean annual screening using: (a) CA-125 serum tumor marker testing, (b) transvaginal ultrasound, and (c) pelvic examinations.

Physical Therapy, Occupational Therapy, Chiropractic Care and Services of Athletic Trainers

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), licensed chiropractor (D.C.), or qualified athletic trainers, limited to a combined total maximum visits per calendar year as outlined in the **Summary of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual provider. No coverage is available when such services are necessitated by Developmental Delay.

Physician Services

You may receive treatment from an In-network or Out-of-Network Physician except where indicated. However, payment is significantly reduced, or not covered, if services are received from an Out-of-Network Physician. Such services are subject to applicable Deductible and Out-of-Pocket requirements.

Preventive Care

Please refer to the **Summary of Benefits** for a complete list of Covered Services. Preventive care services are not subject to the calendar year Deductible when performed by a network provider.

In-Network and Out-of-Network preventive services **for children aged birth through age 5 are never subject to the calendar year Deductible**

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); external breast prostheses used after breast removal.

The following items are **excluded**: corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries; electrical or magnetic continence aids (either anal or urethral); hearing aids or hearing devices; implants for cosmetic purposes except for reconstruction following a mastectomy.

Pulmonary Rehabilitation

Programs require prior authorization and Individual Case Management.

Reconstructive Surgery

Pre-certification is required. Reconstructive surgery does not include any service otherwise excluded in this Certificate Booklet. (See "Limitations and Exclusions")

Reconstructive surgery is covered only to the extent Medically Necessary:

- To restore a function of any body area which has been altered by disease, trauma, congenital/developmental anomalies or previous therapeutic processes;
- To correct congenital defects of a dependent child that lead to functional impairment; and
- To correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

Registered Nurse First Assistant

Covered Services are provided for eligible registered nurse first assistants. Benefits are payable directly to a registered nurse first assistant if such services are payable to a surgical first assistant and such services are performed at the request of a physician and within the scope of a registered nurse first assistant's professional license. No benefits are payable to a registered nurse first assistant who is employed by a Physician or Hospital.

Skilled Nursing Facility Care

Benefits are provided as outlined in the **Summary of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the patient's residence.

Covered Services include:

- Semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this program pays the amount of the semiprivate room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and Radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient;
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for chronic brain syndromes for which no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Specialist Physician

A Member has direct access to specialty care directly from any In-Network Physician. A Member may access specialty care directly from a Specialist Physician; no PCP Referral is needed.

Telemedicine

The practice of telemedicine, by a duly licensed physician or healthcare provider, by means of audio video or data communications (to include secured electronic mail) is a covered benefit.

The use of standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof does not constitute telemedicine service and is not a covered benefit.

The use of telemedicine may substitute for a face-to-face "hands on" encounter for consultation.

To be eligible for payment, interactive audio and video telecommunications must be used, permitting real-time communications between the distant physician or practitioner and the Member / Patient. As a condition of payment, the patient (member) must be present and participating.

Anthem Lumenos HSA

The amount of payment for the professional service provided via telemedicine by the physician or practitioner at the distant site is based on the current Eligible Charges for the service provided. The patient (member) is subject to the applicable deductible and co-insurance based upon their in-network or out-of-network benefits.

Urgent Care Services

Covered Services rendered at contracted Urgent Care Centers are covered as outlined in the **Summary of Benefits**.

Mental Health Care and Substance Abuse Treatment

Hospital Inpatient Care

Benefits for Hospital and Physician Inpatient charges for each Member are stated in the **Summary of Benefits**.

Professional Outpatient Care

Benefits for outpatient charges for each Member (50-55 minute sessions or their equivalent) are stated in the **Summary of Benefits**.

- Professional care in the outpatient department of a Hospital;
- Physician's office visits; and
- Services within the lawful scope of practice of a licensed, approved provider.

Note: To be reimbursable, care must be given by a psychiatrist, a licensed clinical psychologist, neuropsychologist, or a mid-level provider such as a licensed clinical social worker, mental health clinical nurse specialist, a licensed marriage and family therapist, or a licensed professional counselor.

Mental Health Care or Substance Abuse Treatment may be obtained by calling 1-877-812-9777.

Prescription Drug Program

Under this program, you pay the Prescription Drug Coinsurance shown in the **Summary of Benefits** per prescription or prescription refill and Anthem pays the balance.

Your benefit design, as shown in the Summary of Benefits, will determine the Coinsurance of your Prescription Drug Program for preferred formulary drugs and non-preferred drugs that are listed on the Drug Formulary, as well as non-formulary drugs.

At the time the prescription is dispensed, present your Identification Card at the participating pharmacy. The participating pharmacist will complete and submit the claim for you. If you do not go to a participating pharmacy, you will need to submit the itemized bill to be processed.

Benefits

The Prescription Drug Program provides coverage for drugs which, under federal law, may only be dispensed with a prescription written by a Physician. Insulin, which can be obtained over the counter, will only be covered under the Prescription Drug Program when accompanied by a prescription.

This program allows for refills of a prescription within one year of the original prescription date, as authorized by your Physician.

A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires pre-authorization, please call Customer Service.

Covered Services may include:

Retail prescription medications that have been prescribed by a Network Provider and obtained through a participating pharmacy. Retail Prescription Drugs shall, in all cases, be dispensed according to the Drug Formulary for prescriptions written and filled in and out of network. Only those Prescription Drugs included in the Drug Formulary, as amended from time to time by Anthem, may be Covered Services, except as noted below or otherwise provided in the Drug Formulary. Any provider willing to abide by the terms and conditions will be paid at the preferred rate.

Mail Order

Maintenance drugs are available via mail order. To determine if a drug is considered a maintenance drug or requires pre-authorization, please call Customer Service. If a particular drug is not on the list of maintenance drugs, then it is not available through mail order. Be aware that pharmaceuticals received from a mail order distributor can also be obtained from any local pharmacy that agrees to accept the same payment terms as the mail order distributor.

For first-time orders, obtain a prescription from your physician for the maximum days supply allowed by your health plan. Complete an enrollment form and send it, along with the original prescription to:

- WellPoint NextRx Mail Service Pharmacy
P.O. Box 746000
Cincinnati, OH 45274-6000

For refills you have three options:

- **Internet:** <https://www.wellpointnextrx.com> -- Customers will be prompted to login (first time users will be required to register to establish their secure online account. From there, follow the instructions for completing the secure online order form.
- **Mail:** Use a refill order form (these are included with every order) and mail to the address listed above.
- **Phone:** 1-866-825-3475 (TTY/TDD 1-800-221-6915). Customer service is available Monday through Friday, 8:00am-11:00pm and Saturday 8:00am to 7:00pm Eastern Time.

Forms are available online or by calling customer service at the number on your identification card.

Specialty Pharmacy

Specialty Pharmacy are typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Specialty Drugs require preauthorization to be considered Medically Necessary. You may obtain the list of Specialty Drugs by contacting customer service or online at www.anthem.com.

Specialty Drugs are available via mail order and are shipped directly to you or to a Network Provider. Your treatment plan and specific prescription will determine where administration of the drug will occur and by whom. In order to better support your treatment plan, Specialty Drug prescriptions that exceed 30 days may be dispensed in more than one shipment. When this occurs, please note that your total cost for multiple shipments will not exceed the amount you would have incurred for a single shipment.

Additionally, your coinsurance may be prorated to support the method of distribution and treatment. If a Network Provider charges an administration fee for Specialty Drugs, that amount would be separate from the cost of the mail order shipment(s).

Please note that Specialty Drugs may also be obtained from a local pharmacy that agrees to accept the same payment terms as the mail order pharmacy, although your portion of the payment is subject to change.

Drug Formulary

A Member or prospective Member shall be entitled upon request, to a copy of the Drug Formulary Guide, available through our website (www.anthem.com) or as a separate reprint.

Anthem may only modify the Drug Formulary for the following reasons:

- Additions of new drugs, including generics, as they become available.
- Removal of drugs from the marketplace based on either FDA guidance or the manufacturer's decision.
- Re-classification of drugs from formulary preferred to formulary non-preferred or vice versa. All drug reclassifications are overseen by an independent Physician review committee. Changes can occur:
 - Based on new clinical studies indicating additional or new evidence that can either benefit the patient's outcome or that identifies potential harm to the patient.
 - When multiple similar drugs are available such as other drugs within a specific drug class (for example anti-inflammatory drugs, anti-depressants or corticosteroid asthma inhalers;
 - When a brand name drug loses its patent and generics become available; or
 - When brand name drugs become available over the counter.
- Re-classification of drugs to non-formulary status when Therapeutic/Clinically Equivalent drugs are available including over the counter drugs.

Similar drugs mean drugs within the same drug class or type. Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

You will be notified in writing of drugs changing to non-formulary status at least 30 days prior to the effective date of the change if you have had a prescription for the drug within the previous 12 months of coverage under this plan. Drugs considered for non-formulary status are only those with Therapeutic/Clinically Equivalent alternatives.

You may use the prior authorization process to request a non-formulary drug. If your prior approval request is denied, you may exercise your right to appeal. For information regarding either the prior authorization or appeals process, please call the customer service number on your Identification Card.

Georgia law allows You to obtain, without penalty and in a timely fashion, specific drugs and medications not included in the Drug Formulary when:

- You have been taking or using the non-formulary prescription drug prior to its exclusion from the formulary and we determine, after consultation with the prescribing Physician, that the Drug Formulary's Therapeutic/Clinically Equivalent is or has been ineffective in the treatment of the patient's disease or condition; or
- The prescribing Physician determines that the Drug Formulary's Therapeutic/Clinically Equivalent drug causes, or is reasonably expected to cause, adverse or harmful reactions in the patient.

Off-Label Drugs

When prescribed for an individual with a life-threatening or chronic and disabling condition or disease benefits are provided for the following:

- Off-Label Drugs
- Medically Necessary services associated with the administration of such a drug.

An off-Label Drug is one that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration.

Voluntary Half-Tablet Program

The Half-Tablet Program will allow members to pay fewer instances of coinsurance on selected "once daily dosage" medications. The Half-Tablet Program allows a member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the physician to take "½ tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the member's decision to participate should follow consultation with and the concurrence of his/her physician. To obtain a list of the products available on this program contact 1-866-467-3088.

The following are not Covered Services under this Contract:

- Prescription Drug products for any amount dispensed which exceed the FDA clinically recommended dosing schedule.
- Prescription Drugs received through an Internet pharmacy provider.
- Non-Legend Vitamins.
- Smoking cessation products.
- Over-the-counter items.
- Cosmetic Drugs.
- Appetite Suppressants.
- Weight Loss Products.
- Diet supplements.
- Syringes (for use other than insulin) except when in coordination with an approved injectable.
- Non-contraceptive injectables (except with pre-certification).
- The administration or injection of any Prescription Drug or any drugs or medicines.
- Prescription Drugs which are entirely consumed or administered at the time and place where the prescription order is issued.
- Prescription refills in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the prescription order.
- Prescription Drugs for which there is no charge.
- Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use.
- Prescription Drugs for use as an Inpatient or outpatient in a Hospital and Prescription Drugs provided for use in a convalescent care facility or nursing home which are ordinarily furnished by such facility for the care and treatment of Inpatients.
- Charges for delivery of any Prescription Drugs.
- Drugs and medicines which do not require a prescription order and which are not Prescription Drugs.

Anthem Lumenos HSA

- Prescription Drugs provided by a Physician whether or not a charge is made for such Prescription Drugs.
- Prescription Drugs which are not Medically Necessary or which Anthem determines are not consistent with the diagnosis.
- Prescription Drugs which Anthem determines are not provided in accordance with accepted professional medical standards in the United States.
- Any services or supplies which are not specifically listed as covered under this Prescription Drug program.
- Prescription Drugs which are Experimental or Investigational in nature as explained in the “Limitations and Exclusions” section.
- Vaccines delivered by nasal spray or mist.
- Prescription medicine for nail fungus except for immunocompromised or diabetic patients.
- Non-formulary drugs except as described in this Prescription Drug Program section.

Limitations and Exclusions

The pre-existing limitation applies only to Out-of-Network services.

Pre-existing Conditions

Until coverage for a Member enrolled under this Contract (or any prior Creditable Coverage) has been in force for twelve consecutive months (except for Maternity Care), benefits for services to be paid by this program shall not be available for any illness, Injury or other condition for which:

- Medical advice, diagnosis, care, or treatment was recommended or received within the previous six months preceding the Effective Date of coverage of an individual Member.
- The Effective Date of coverage is subject to any length-of-service provision your employer requires; however, you will receive credit toward your pre-existing condition waiting period for any employee length-of-service requirement which you must serve.

Unsatisfied Waiting Period Requirements

Any remaining portion of pre-existing waiting-period requirements not satisfied under prior Creditable Coverage must be fulfilled.

What's Not Covered

Your coverage does not provide benefits for:

- **Allergy Services** - Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- **Acupuncture** - Acupuncture and acupuncture therapy.
- **Beautification Procedures** - Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by Anthem, is not covered.
 - This exclusion does not apply to surgery to restore function if any body area has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.
 - The following criteria must be met to qualify for breast reduction surgery: the affected area must be more than 250 grams over the normative average. Breast reduction surgery must meet certain criteria for coverage including a tissue removal minimum.
 - This exclusion does not apply to Breast Reconstructive Surgery. Please see the "Benefits" section of this Certificate Booklet.
- **Before Coverage Begins** - Services rendered or supplies provided before coverage begins, i.e., before a Participant's Effective Date, or after coverage ends. Such services and supplies shall include but not be limited to Inpatient Hospital admissions which begin before a Participant's Effective Date, continue after the Participant's Effective Date, and are covered by a prior carrier.
- **Behavioral Disorders** - Educational services and treatment of behavioral disorders, together with services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, Developmental Delay (when it is less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test), including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Contract provides for neurological

disorders), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Neither physical nor occupational therapy is covered for Developmental Delay. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered.

- **Biomicroscopy** - Biomicroscopy, field charting or aniseikonic investigation.
- **Care, Supplies, or Equipment** - Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant's house or place of business, and adjustments made to vehicles.
- **Complications** - Complications of non-covered procedures are not covered.
- **Counseling** - Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
- **Court-Ordered Services** - Court-ordered services, or those required by court order as a condition of parole or probation.
- **Covered Services** - Any item, service, supply or care not specifically listed as a Covered Service in this Certificate Booklet.
- **Crime** - Injuries received while committing a crime.
- **Daily Room Charges** - Daily room charges while the Contract is paying for an Intensive Care, cardiac care, or other special care unit.
- **Dental Care** - Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (including impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this SPD Booklet.
- **Drugs** - Any drug or other item which does not require a prescription.
- **Durable Medical Equipment** - The following items related to Durable Medical Equipment are specifically *excluded*:
 - Air conditioners, humidifiers, dehumidifiers, or purifiers;
 - Arch supports and orthopedic or corrective shoes;
 - Heating pads, hot water bottles, home enema equipment, or rubber gloves;
 - Sterile water;
 - Deluxe equipment or premium services, such as motor driven chairs or beds, when standard equipment is adequate;
 - Rental or purchase of equipment if you are in a facility which provides such equipment;
 - Electric stair chairs or elevator chairs;
 - Physical fitness, exercise, or ultraviolet/tanning equipment;
 - Residential structural modification to facilitate the use of equipment;
 - Other items of equipment which Anthem feels do not meet the listed criteria.
- **Employer-Run Care** - Care given by a medical department or clinic run by your employer.
- **Experimental or Investigational** - Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in Anthem's judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a Participant's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

Anthem Lumenos HSA

- **Failure to Keep a Scheduled Visit** - Charges for failure to keep a scheduled visit or for completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.
- **Foot Care** - Care of corns, bunions (except capsular or related surgery), calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.
- **Free Services** - Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.
- **Government Programs** - Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
- **Hair** - Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
- **Hearing Services** - Hearing aids, hearing devices and related or routine examinations and services.
- **Homes** - Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
- **Hypnotherapy.**
- **Ineligible Hospital** - Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
- **Ineligible Provider** - Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
- **Infertility** - Services related to or performed in conjunction with artificial insemination, in-vitro fertilization, reverse sterilization or a combination thereof.
- **Injury or Illness** - Care, supplies, or equipment not Medically Necessary, as determined by Anthem, for the treatment of an Injury or illness.
- **Inpatient Mental Health** - Inpatient Hospital care for mental health conditions when the stay is:
 - determined to be court-ordered, custodial, or solely for the purpose of environmental control;
 - rendered in a home, halfway house, school, or domiciliary institution;
 - associated with the diagnosis(es) of acute stress reaction, childhood or adolescent adjustment reaction, and/or related marital, social, cultural or work situations.
- **Inpatient Rehabilitation** - Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
 - the treatment is for maintenance therapy; or
 - the Participant has no restorative potential; or
 - the treatment is for congenital learning or neurological disability/disorder; or
 - the treatment is for communication training, educational training or vocational training.
- **Medical Reports** - Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- **Medicare** - Services paid under Medicare or which would have been paid if the Participant had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Participant has enrolled in Medicare Part B.
- **Methadone** - Methadone is excluded for coverage when used (1) for any maintenance program and/or for the treatment of drug addiction or dependency (unless the Contract has mental health outpatient benefits) and (2) for the management of chronic, non-malignant pain and/or any off-label usage which does not meet established off-label coverage guidelines. Such maintenance programs must meet Medical Necessity requirements.
- **Miscellaneous Care** - Custodial Care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to

another area for medical care is also excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.

- **Non-Physician Care** - Care prescribed and supervised by someone other than a Physician unless performed by other licensed health care Providers as listed in this Certificate Booklet.
- **Not Medically Required** - Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
- **Obesity** –Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it is the sole means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care or counseling. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include but are not limited to bariatric services, bariatric surgery (e. g., gastric bypass or vertically banded gastroplasty, liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw).
- **Orthoptics** - Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
- **Outpatient Therapy or Rehabilitation** - Services for outpatient therapy or rehabilitation other than those specifically listed in this Certificate Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment of nicotine addiction, and carbon dioxide.
- **Personal Comfort Items** - Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
- **Private Room** - Private room, except as specified as Covered Services.
- **Private Duty Nursing**
- **Provider (Close Relative)** - Services rendered by a Provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
- **Routine Physical Examinations** - Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this Certificate Booklet.
- **Safe Surrounding** - Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
- **Sclerotherapy** - Sclerotherapy of extremity veins.
- **Self-Help** - Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
- **Sexual Modification/Dysfunction Treatments** - Surgical or medical treatment or study related to the modification of sex (transsexualism) or medical or surgical services or supplies for treatment of sexual dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction.)
- **Shoes** - Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
- **Skilled Nursing Facility** - Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.

Anthem Lumenos HSA

- **Telehealth** - Telehealth consultations will not be reimbursable for the use of audio-only telephone, facsimile machine or electronic mail.
- **Thermograms** - Thermograms and thermography.
- **Transplants** - The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
 - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
 - Transportation, travel or lodging expenses for non-donor family members;
 - Donation related services or supplies associated with organ acquisition and procurement;
 - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
 - Any transplant not specifically listed as covered.
- **Transportation** - Transportation provided by other than a state licensed Professional Ambulance Service, and ambulance services other than in a Medical Emergency. Ambulance transportation from the Hospital to the home is not covered.
- **Treatment (Outside U.S.)** - Non-emergency treatment of chronic illnesses received outside the United States performed without authorization.
- **Usual, Customary and Reasonable Fees** - Expenses in excess of Usual, Customary and Reasonable Fees (as determined by Anthem).
- **Vision** - Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Eye Refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service.
- **Vision (Surgical Correction)** - Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
- **Waived Fees** - Any portion of a Provider's fee or charge which is ordinarily due from a Participant but which has been waived. If a Provider routinely waives (does not require the Participant to pay) a Deductible or Out-of-Pocket amount, Anthem will calculate the actual Provider fee or charge by reducing the fee or charge by the amount waived.
- **War** - Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.
- **Workers' Compensation** - Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. Exception: Benefits are provided for actively employed partners and small business owners not covered under a Workers' Compensation Act or similar law, if elected by the Group and additional Premium is paid.

Coordination of Benefits (COB)

If you, your spouse, or your Dependents have duplicate coverage under another Anthem group program, any other group medical expense coverage, or any local, state or governmental program, (except school accident insurance coverage and Medicaid) then benefits payable under this Contract will be coordinated with the benefits payable under the other program. Anthem's liability in coordinating will not be more than 100% UCR or the contracted amount.

Allowable Expense means any necessary, reasonable and customary expense at least a portion of which is covered under at least one of the programs covering the person for whom claim is made. The claim determination period is the calendar year.

Order of Benefit Determination

When you have duplicate coverage, claims will be paid as follows:

- **Automobile Insurance.** Medical benefits available through automobile insurance coverage will be determined before that of any other program if the automobile coverage has either no order of benefit determination rules or it has rules which differ from those permitted under applicable Georgia Insurance Regulations.
- **Non-Dependent/Dependent.** The benefits of the program which covers the person as an Employee (other than as a Dependent) are determined before those of the program which covers the person as a Dependent.
- **Dependent Child/Parents Not Separated or Divorced.** Except as stated below, when this program and another program cover the same child as a Dependent of different persons, called "**parents**":
 - The benefits of the program of the parent whose birthday falls earlier in a year are determined before those of the program of the parent whose birthday falls later in that year.
 - If both parents have the same birthday, the benefits of the program which covered the parent longer are determined before those of the program which covered the other parent for a shorter period of time.However, if the other program does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the programs do not agree on the order of benefits, the rule in the other program will determine the order of benefits.
- **Dependent Child/Parents Separated or Divorced.** If two or more programs cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - first, the program of the parent with custody of the child;
 - then, the program of the spouse of the parent with the custody of the child; and
 - finally, the program of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the company obligated to pay or provide the benefits of the program of that parent has actual knowledge of those terms, the benefits of that program are determined first. This paragraph does not apply with respect to any claim determination period or program year during which any benefits are actually paid or provided before the company has that actual knowledge.

- **Joint Custody.** If the specific terms of a court decree state that the parents shall have joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the programs covering the child shall follow the order of benefit determination rules outlined above for "Dependent Child/Parents not Separated or Divorced".
- **Active/Inactive Employee.** The benefits of a program that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a program that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other program does not have this rule, and if, as a result, the programs do not agree on the order of benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage.** If none of the above rules determine the order of benefits, the benefits of the program which covered an Employee or Member longer are determined before those of the program that covered that person for the shorter time.

Effects on the Benefits of This Program

This section applies when, in accordance with the Order of Benefit Determination Rules, this program is a secondary program to one or more other programs. In that event the benefits of this program may be reduced under this section. Such other program or programs are referred to as “the other programs” below.

Reduction in this program’s benefits. The benefits of this program will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expenses under this program in the absence of this COB provision; and
- the benefits that would be payable for the Allowable Expenses under the other programs, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceed those Allowable Expenses in a claim determination period. In that case, the benefits of this program will be reduced so that they and the benefits payable under the other programs do not total more than those Allowable Expenses.

When the benefits of this program are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this program.

Miscellaneous Rights

- **Right to Receive and Release Necessary Information.** Certain facts are needed to apply these COB rules. Anthem has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person as necessary to coordinate benefits. Anthem need not tell, or get the consent of, any person to do this. Each person claiming benefits under this program must give Anthem any facts it needs to pay the claim.
- **Facility of Payment.** A payment made under another program may include an amount which should have been paid under this program. If it does, Anthem may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this program. Anthem will not have to pay that amount again.
- **Right of Recovery.** If the amount of the payment made by Anthem is more than it should have paid under this COB provision, it may recover the excess from one or more of:
 - the persons it has paid or for whom it has paid,
 - insurance companies; or
 - other organizations.

Right of Recovery

If you or your Covered Dependents have a claim for damages or a right to reimbursement from a third party or parties for any condition, illness or Injury for which benefits are paid under this program, Anthem shall have a right of recovery. Anthem's right of recovery shall be limited to the amount of any benefits paid for covered medical expenses under this program, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. Anthem's right of recovery shall include compromise settlements. You or your attorney must inform Anthem of any legal action or settlement discussion, ten days prior to settlement or trial. Anthem will then notify you of the amount it seeks, and the amount of your legal expenses it will pay.

Claims and General Information

Member Rights and Responsibilities

Your rights as an Anthem Member.

As a Member, you have the right to:

- Recommend changes to the Members' Rights and Responsibilities policy.
- Receive information about the Plan, its services, its providers, and about your Rights and Responsibilities as a Member.
- Choose your primary care Physician from Anthem's network directory listing Participating Providers and change your PCP.
- Receive considerate and courteous service with respect for personal privacy and human dignity through the Plan in a timely manner.
- Expect the Plan to implement policies and procedures to ensure the confidentiality of all your personal health information.
- Participate in full discussion with your Provider concerning the diagnosis, appropriate or Medically Necessary treatment options, and the prognosis of your conditions, regardless of whether or not the information represents a covered treatment or benefit.
- Receive and be informed about where, when, and how to obtain all benefits to which you are entitled under your Contract including access to routine services, as well as after-hours and emergency services.
- Be informed of your Premiums, Deductibles, Coinsurance and any maximum limits on out-of-pocket expenses for items and services (both In- and Out-of-Network).
- Receive Plan rules regarding Deductibles and pre-certification including, but not limited to, pre-certification, concurrent review, post service review, or post payment review that could result in your being denied coverage of a specific service.
- Participate with providers in the decision-making process concerning your health care.
- Refuse treatment and be informed by your Physician of the medical consequences.
- Receive specific information, upon your request, from Network Providers including, but not limited to, accreditation status, accessibility of translation or interpretation services, and credentials of providers of direct patient care (limited to contracted providers). Anthem encourages Network Providers to disclose such information upon Member request.
- Receive, upon request, a summary of how Physicians, Hospitals and other providers are compensated using a variety of methodologies, including fee-for-service, per diem, discounted charges and global reimbursement.
- Express your opinions, concerns, or complaints about the Plan and the care provided by Network Providers in a constructive manner to the appropriate people within the Plan and be given the right to register your complaints and to appeal Plan decisions.
- Receive, upon request, a summary of the number, nature and outcome of all formally filed grievances filed with the Plan in the previous three years.
- Receive timely access to medical records and health information maintained by the Plan in accordance with applicable federal and state laws.

Your Responsibilities as an Anthem Member

As a Member, you have the responsibility to:

- Maintain your health and participate in the decisions concerning treatment.
- Ask questions and make certain that you understand the explanations and instructions you are given by your Physician, and comply with those conditions.
- Identify yourself as a Member when scheduling appointments or seeking specialty care, and pay any applicable Coinsurance or out-of-pocket expenses in a timely manner.
- Keep scheduled appointments or give adequate notice of delay or cancellation.
- Furnish information regarding other health insurance coverage.

- Treat all network Physicians and personnel respectfully and courteously as partners in good health care.
- Permit Anthem to review your medical records as part of quality management initiatives in order to comply with regulatory bodies.
- Provide, to the extent possible, information that the Plan and its providers need in order to care for you.
- Follow the plans and instructions for care that you have agreed on with your Physicians.

Proof of Loss, Payment of Claims

In-network Providers

When services are provided by an In-Network Provider, claims will be filed by that Provider. You are not responsible for filing any claims when services are rendered by an In-Network Provider.

In-network Providers are Providers who have signed a Network Contract with Anthem to provide Covered Services to Members covered under an Anthem contract.

It is anticipated that a Member will make payment to a Physician or Provider providing services under this Contract only to comply with those Deductible and Out-of-Pocket requirements outlined in the **Summary of Benefits**. We are authorized by you or the Group to make payments directly to the Provider of Covered Services.

Out-of-network Providers

When Covered Services are rendered Out-of-network, services are performed by Participating or Non-contracted Providers. See the "Definitions" section of this Certificate Booklet for an explanation of each term.

Each person enrolled through the Group's Contract receives an Identification Card. When admitted to an Anthem Participating Hospital, present your Identification Card. Upon discharge, you will be billed only for those charges not covered by your Group Contract. The Hospital will bill us directly for Covered Services.

If you are admitted to a Non-Contracted Hospital, inform the admitting personnel of your coverage. When discharged, send a copy of the Hospital's itemized bill to us. Payment for Covered Services will be sent directly to you.

When you receive Covered Services from a Participating Physician (doctor) or other Participating health-care provider, ask him or her to complete a Physician's Service Report form. Payment for Covered Services will be made directly to the Participating Physician or Participating Provider.

For health-care expenses other than those billed by a Participating Hospital or licensed health-care provider, use the Anthem claim form to file your claims. You may obtain these from your employer or us. Claims should include your name, Member and Group numbers exactly as they appear on your Identification Card. Attach all bills to the claim form and send to us. Make certain they are itemized to include dates, places and nature of services or supplies. The address is on the claim form. Be sure to keep a photocopy of all forms and bills for your records.

Processing Your Claim

You are responsible for submitting your claims for Covered Services not billed by and payable to a Hospital or Physician. Always make certain you have your Identification Card with you. Be sure Hospital or Physician's office personnel copy your name, Group and Member numbers accurately when completing forms relating to your coverage.

If you are hospitalized outside Georgia, the claim for Participating Hospital services is usually handled in the same manner as Participating Hospitals within the state and the Hospital files the claim through its

local Blue Cross and Blue Shield office. It may, however, be necessary for you to pay the Hospital or attending Physician for his or her services and then submit an itemized statement to us when you return home.

Timeliness of Filing and Payment of Claims (Out-of-Network and Out-of-Area)

In the event you submit a claim to receive benefits, a properly completed claim form with any necessary reports and records must be filed by the Member within 90 days of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, we will notify you within 15 working days of the reason for the delay and list all information needed to continue processing your claim. After this data is received by us, claims processing will be completed during the next 15 working days. We shall pay interest at the rate of 18% per year to you or the assigned provider if we do not meet these requirements.

Necessary Information

In order to process your claim, Anthem may need information from the provider of the service. As a Member, you agree to authorize the Physician, Hospital, or other provider to release necessary information.

Anthem will consider such information confidential. However, Anthem has the right to use this information to defend or explain a denied claim.

Balance Billing

Participating Physicians are prohibited from balance billing. A Participating Physician has signed an agreement with Anthem to accept our determination of the usual, customary and reasonable fee for covered services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Contract, e.g., Deductibles or Coinsurance.

Unauthorized Use of Identification Card / Fraudulent Statements

If you permit an Anthem Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Fraudulent statements on Subscriber application forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Subscriber's coverage. This includes fraudulent acts to obtain medical services and/or prescription drugs.

Questions About Coverage or Claims

If you have questions about your coverage, contact your Plan Administrator or Anthem's Customer Service Department. Be sure to always give your Member ID number. If you wish to get a full copy of the Utilization Review program procedures, contact the Customer Service Department.

Write

Customer Service Department
Anthem Blue Cross and Blue Shield
P.O. Box 9907
Columbus, Georgia 31908

When asking about a claim, give the following information:

- Member ID number;
- patient name; Subscriber name and address;
- date of service; type of service received; and
- provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is an Anthem Network Provider, call them directly or call Anthem.

Right to Appeal

For all claims submitted by you or in your behalf, you will receive a notice (Explanation of Benefits) showing the amount charged; the amount paid by the program; and, if payment is partially or wholly denied, the reason.

If your claim is denied, you can appeal as outlined below. Any legal action must be brought within three years after the date the services or supplies were provided.

We Want You to be Satisfied

Anthem hopes that you will always be satisfied with the level of service provided to you and your family. Anthem realizes, however, that there may be times when problems arise and miscommunications occur which lead to feelings of dissatisfaction.

Complaints about Anthem Service

As a BlueChoice PPO Member, you have a right to express dissatisfaction and expect unbiased resolution of issues. The following represents the process established to ensure that Anthem gives its fullest attention to your concerns. Please utilize it to tell Anthem when you are displeased with any aspect of services rendered.

- Call the Customer Service Department. The phone number is on your ID Card. Tell us your problem and we will work to resolve it for you as quickly as possible.
- If you are not satisfied with our answer, you may file a formal complaint, preferably, but not necessarily, in writing. This request for a further review of your concerns should be addressed to the location provided by the Customer Service Representative at the number on your ID Card.
- If, depending on the nature of your complaint, you remain dissatisfied after receiving our response, you will be offered the right to appeal our decision. At the conclusion of this formalized re-review of your specific concerns, a final written response will be generated to you, which will hopefully bring the matter to a satisfactory conclusion for you.

Summary of Grievances

A summary of the number, nature and outcome results of grievances filed in the previous three years is available for your inspection. You may obtain a copy of any such summary at a reasonable cost from Anthem.

Complaints about Provider Service

If your complaint involves care received from a provider, please call the Customer Service number. Your complaint will be resolved in a timely manner.

Terms of Your Coverage

Anthem provides the benefits described in this booklet only for eligible Members. The health care services are subject to the limitations, exclusions, Deductible, and Coinsurance requirements specified in this booklet. Any group Anthem contract or certificate which you received previously will be replaced by this Contract.

Benefit payment for Covered Services or supplies will be made directly to Network or Participating Providers. A Member may assign benefits to a provider who is not a Network or Participating Provider, but it is not required. If a Member does not assign benefits to a Non-network or Non-Participating Provider, any benefit payment will be sent to the Member.

Anthem does not supply you with a Hospital or Physician. In addition, Anthem is not responsible for any Injuries or damages you may suffer due to actions of any Hospital, Physician or other person. In order to process your claims, Anthem may request additional information about the medical treatment you

received and/or other group health insurance you may have. This information will be treated confidentially.

An oral explanation of your benefits by an Anthem employee is not legally binding.

Any correspondence mailed to you will be sent to your most current address. You are responsible for notifying Anthem of your new address.

General Information

Fraudulent statements on Subscriber application forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Subscriber's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Both parties to this Contract (the employer and Anthem) are relieved of their responsibilities without breach, if their duties become impossible to perform by acts of God, war, terrorism, fire, etc.

Anthem will adhere to the employer's instructions and allow the employer to meet all of the employer's responsibilities under applicable state and federal law. It is the employer's responsibility to adhere to all applicable state and federal laws and Anthem does not assume any responsibility for compliance.

Small Group Rating

A Member covered under a small group contract (from 2 to 50 Employees) is entitled to receive upon request certain rating information which documents the benefit design, demographic factors and Group experience factors since the pool rate utilized in the small Group's previous rating period. Anthem will respond to such request within ten (10) business days of the request for information.

Changes in Coverage

Your employer and Anthem may mutually agree to change the benefits described in this booklet. Fees charged for benefits described in this booklet may be changed:

- if the level of benefits changes; or
- if the ratio of benefits to fees exceeds an established level.

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

Licensed Controlled Affiliate

The Member hereby expressly acknowledges his/her understanding that this policy constitutes a contract solely between the Member Group and Anthem, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Anthem to use the Blue Cross and Blue Shield Service Marks in the state of Georgia, and that Anthem is not contracting as the agent of the Association. The Member Group further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Member for any of Anthem's obligation to the Member created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Calculation of Coinsurance and Other Subscriber Liability

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

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

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

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

Care Received Outside the United States

You will receive Contract benefits for care and treatment received outside the United States. Contract provisions will apply. Any care received must be a Covered Service. Please pay the provider of service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with your claim. Anthem will reimburse you directly. Payment will be based on Eligible Charges and based on the UCR of the Member’s legal residence (i.e., local UCR). Assignments of benefits to foreign providers or facilities cannot be honored.

Medicare

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

Except when federal law requires Anthem to be the primary payor, the benefits under this Certificate Booklet for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members, to the extent Anthem has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, Anthem will calculate benefits as if they had enrolled. For Medicare Part D, Anthem will calculate benefits upon receipt of the Member’s Explanation of Medicare Benefits (EOMB) or Part D payment data obtained from an authorized Prescription Benefit Manager (PBM).

Governmental Health Care Programs

If you are enrolled in a group with fewer than 20 employees, your benefits will be reduced if you are eligible for coverage (even if you did not enroll) under any federal, state (except Medicaid) or local government health care program.

Under federal law, for groups with 20 or more employees, all active employees (regardless of age) can remain on the group’s health plan and receive group benefits as primary coverage. Also, spouses (regardless of age) of active employees can remain on the group’s health plan and receive group benefits as primary coverage.

When Your Coverage Terminates

A. Termination of Coverage (Group)

Anthem may cancel this Contract in the event of any of the following:

- The Group fails to pay premiums in accordance with the terms of this Contract.
- The Group performs an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage.
- The Group has fallen below our minimum employer contribution or group participation rules. We will submit a written notice to the Group and provide the Group 60 days to comply with these rules.
- We terminate, cancel or non-renew all coverage under a particular policy form, provided that:
 - We provide at least 180 days notice of the termination of the policy form to all Members;
 - We offer the Group all other small group (employer) or large group (employer) policies, depending on the size of the Group, currently being offered or renewed by us for which you are otherwise eligible; and
 - We act uniformly without regard to the claims experience or any health status related factor of the individuals insured or eligible to be insured.

B. Termination of Coverage (Individual)

Group program membership for you and your enrolled family members may be continued as long as you are employed by the Group and meet eligibility requirements. It ceases if your employment ends, if you no longer meet eligibility requirements, if the Group Contract ceases, or if you fail to make any required contribution toward the cost of your coverage. In any case, your coverage would end at the expiration of the period covered by your last contribution.

Coverage of an enrolled child ceases automatically when the child marries or attains age 19 (except students covered to age 26), whichever occurs first. Coverage of an unmarried handicapped child over age 19 ceases if the child is found to be no longer totally or permanently disabled. Coverage of the spouse of a Member terminates automatically as of the date of divorce or death.

Should you or any family members be receiving covered care in the Hospital at the time your membership terminates for reasons other than your employer's cancellation of this Contract, or failure to pay the required subscription charges, benefits for Hospital Inpatient care will be provided only to the extent available for that Hospital stay.

C. Continuation of Coverage (Georgia Law)

Any Employee insured in Georgia under a company welfare benefit plan whose employment is terminated other than for cause, may be entitled to certain continuation benefits. If you have been continuously enrolled for at least six months under this Contract, or this and its immediately preceding health insurance contract, you may elect to continue Group health coverage for yourself and your enrolled family members for the rest of the month of termination and three additional months by paying the appropriate Premium.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation independently.

Cost

These continuation benefits are available without proof of insurability at the same Premium rate charged for similarly insured Employees. To elect this benefit you must notify the company's Group health benefit Plan Administrator within 30 days of the date your coverage would otherwise cease that you wish to continue your coverage and you must pay the required monthly Premiums in advance.

This continuation benefit is not available if:

- your employment is terminated for cause; or
- your health plan enrollment was terminated for your failure to pay a Premium or Premium contribution; or

Anthem Lumenos HSA

- your health plan enrollment is terminated and replaced without interruption by another group contract; or
- health insurance is terminated for the entire class of Employees to which you belong; or
- the Group terminates health insurance for all Employees.

Termination of Benefits

Continuation coverage terminates if you do not pay the required Premium on time or you enroll for other group insurance or Medicare.

Conversion

Conversion rights during the continuation period are the same as for insured Employees. If the Group terminates its health insurance Contract during an Employee's continuation period, the Plan Administrator must notify continuing Employees that conversion rights must be exercised within 31 days.

D. Continuation of Coverage (Federal Law-COBRA)

If your coverage ends under the plan, you may be entitled to elect continuation coverage in accordance with federal law. If your employer normally employs 20 or more people, and your employment is terminated for any reason other than gross misconduct, instead of the three months continuation benefit described above, you may elect from 18-36 months of continuation benefits, regardless of whether the Group is insured or self-funded.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Employee during the period of continuation coverage is also eligible for election of continuation coverage.

<u>Initial Qualifying Event</u>	<u>Length of Availability of Coverage</u>
<u>For Employees:</u> <u>Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked</u>	<u>18 months</u>
<u>For Spouses/ Dependents:</u> <u>A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours Worked</u>	<u>18 months</u>
<u>Covered Employee's Entitlement to Medicare</u>	<u>36 months</u>
<u>Divorce or Legal Separation</u>	<u>36 months</u>
<u>Death of a Covered Employee</u>	<u>36 months</u>
<u>For Dependents:</u> <u>Loss of Dependent Child Status</u>	<u>36 months</u>

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her spouse and dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during their initial 18 months of COBRA continuation coverage (or 29 months, if the disability provision applies), your spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your spouse or dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of your termination, lay-off, reduction in work hours or Medicare entitlement, your employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of your divorce, legal separation or the failure of your enrolled Dependents to meet the program's definition of Dependent. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, you or an eligible family member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the premium rate changes for active associates, your monthly premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employee's Dependents are also eligible for the 18 to 29-month disability extension. This provision also applies if any covered family member is found to be disabled. This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.

Continuation of Coverage (Federal Law – USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Member (or his or her Dependents) is covered under this Contract, and if becomes absent from employment by reason of military leave, the Member (or his or her Dependents) may have the right to elect to continue health coverage under this Contract. In order to be eligible for coverage during the period that the Member is gone on military leave, the Member must give reasonable notice to the Employer of his or her military leave and the Member will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Member and his or her Dependents can elect to continue coverage under this Contract for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Member to apply for or return to work with the Employer. During military leave the Member is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Member's absence is less than 31 days, the Employer must continue to pay its portion of the premiums and the Member is only required to pay his or her share of the premiums without the COBRA-type 2% administrative surcharge.

Also, when the Member returns to work, if the Member meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Member did not elect COBRA continuation. These requirements are (i) the Member gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Member must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Member must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). You may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Member upon reemployment, as well as to any Dependent who has become covered under this Contract by reason of the Member's reinstatement of coverage.

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 65% of the cost for health coverage for you and your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage provider, reducing the amount you have to pay out-of-pocket.

E. When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a covered individual reaches the end of the maximum coverage period
- a covered individual fails to pay a required Premium on time
- a covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease.
- a covered individual becomes entitled to Medicare after electing COBRA
- the Group terminates all of its group welfare benefit plans.

F. Continuation of Coverage (Age 60 and Over)

An Employee (and eligible Dependents), insured in Georgia under a company welfare benefit plan, who has exhausted the continuation benefits listed above, is eligible for additional continuation rights if that Employee was age 60 or older and covered for continuation benefits under the regular continuation provision.

There are certain requirements, which must be met:

- you must have been covered under a group plan which covers 20 or more employees; and
- you must have been continuously enrolled for at least six months under this Contract.

This continuation benefit is not available if:

- your employment is terminated voluntarily for other than health reasons;
- the health plan enrollment was terminated because you failed to pay a Premium or Premium contribution;
- the health plan enrollment is terminated and replaced without interruption by another group contract;
- health insurance is terminated for the entire class of Employees to which you belong;
- the Group terminated health insurance for all Employees;
- your employment was terminated due to reasons which would cause a forfeiture of unemployment compensation (Chapter 8 of Title 34 "Employment Security Law").

The following eligibility requirements apply:

- you must have been 60 years of age or older on the date coverage began under the continuation provision;
- your Dependents are eligible for coverage if you meet the above requirements;
- your spouse and any Covered Dependent children whose coverage would otherwise terminate because of divorce, legal separation, or your death may continue if the surviving spouse is 60 years of age or older at the time of divorce, legal separation or death.

The monthly charge (Premium) for this continuation coverage will not be greater than 120% of the amount you would be charged as a normal Group Member. You must pay the first Premium for this continuation of coverage under this provision on the regular due date following the expiration of the period of coverage provided under COBRA or state continuation.

Your continuation rights terminate on the earliest of the following:

- the date you fail to pay any required Premium when due;
- the date the Group Contract is terminated; (If the Group Contract is replaced, coverage will continue under the new Group plan.)
- the date you become insured under any other Group health plan;
- the date you or your divorced or surviving spouse becomes eligible for Medicare.

G. Extension of Benefits in Case of Total Disability

If the Group Contract is terminated for non-payment of subscription charges, or if the Group terminates the Contract for any reason, or if the Contract is terminated by us (with 60 days written notice), then in such event the coverage of a totally disabled Subscriber will be as follows:

Contract benefits for the care and treatment of the specific illness, disease or condition that caused the total disability will be extended up to twelve (12) months from the date of termination of the Group Contract or to the maximum of the amount payable under this Contract during the extension period.

NOTE: We consider total disability a condition resulting from disease or Injury where:

- the Member is not able to perform the major duties of his or her occupation and is not able to work for wages or profit; or
- the Member's Dependent is not able to engage in most of the normal activities of a person of the same age and sex.

H. Special Requirements for COBRA and Conversion Rights

- COBRA is the first available option for continuing coverage.
- Any COBRA benefits must be exhausted for the entire COBRA eligibility period before conversion coverage will be provided.
- No conversion rights are available if a Member is enrolled or eligible for other group coverage.

I. Extended Benefits

If a Member's coverage ends and he or she is totally disabled and, under a Physician's care Anthem extends major medical benefits for that Member under this Contract as explained below. This is done at no cost to the Member.

Anthem only extends benefits for Eligible Charges due to the disabling condition. The Eligible Charges must be incurred before the extension ends. What Anthem pays is based on all the terms of this Contract.

Anthem does not pay for charges due to other conditions. Anthem does not pay for charges incurred by other covered Dependents.

The extension ends on the earliest of: (a) the date the total disability ends or (b) one year from the date the Member's coverage under this Contract ends. It also ends if the Member has reached the payment limit for his or her disabling condition.

NOTE: Anthem considers total disability a condition resulting from disease or Injury where:

- The Member is not able to perform the major duties of his or her occupation and is not able to work for wages or profit; or
- The Member's Dependent is not able to engage in most of the normal activities of a person of the same age and sex.

J. Enhanced Conversion Rights

You and/or your Dependents may be a "qualifying eligible individual" for an enhanced conversion product if:

- your most recent coverage was under a group plan or continuation coverage;
- coverage under this Contract has been terminated for any reason other than fraud or failure to pay a required Premium;
- all continuation (COBRA) coverage has been exhausted;
- there is 18 months of prior Creditable Coverage immediately prior to termination;
- you are not eligible for, nor have declined, any of the following:
 1. Any group health policy (including continuation under COBRA or state continuation);
 2. Medicare;
 3. Medicaid or a similar program;
- you are not covered under any other creditable health insurance coverage, including individual or student health coverage.

You must file a substantially completed application for such enhanced conversion coverage, and pay the first Premium, no later than 63 consecutive days after a qualifying event, or the date of notice of enhanced conversion rights, whichever is later.

If you do not qualify for enhanced conversion rights, you may qualify for standard conversion rights as set out below.

K. Conversion Rights

NOTE: This section applies after you have exhausted any applicable continuation rights. A Member must have been covered under this Group Contract for six consecutive months in order to be eligible for conversion benefits.

A direct pay, billed-at-home contract providing Hospital and surgical benefits may be obtained, without medical examination or other evidence of insurability by:

- you, when your employment is terminated (group conversion contract only);
- your surviving spouse, when your coverage is terminated due to your death;
- your child/children no longer eligible under your coverage (group conversion contract only); or
- your spouse, when coverage is lost due to termination of the marriage;

provided we are notified within 31 days after termination of insurance. Information as to the coverage available and Premium rates can be obtained from us.

Any divorced spouse or widow/widower may apply within 31 days for a direct pay coverage contract most nearly similar to this Contract or any contract providing lesser coverage than being offered by us. This new Contract will be issued without evidence of insurability and will become effective on payment of the charge for the new coverage.

Time you have earned toward waiting periods under this contract would carry over to the new contract.

Definitions

Accidental Injury

Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. It does not include injuries for which benefits are provided under any Workers' Compensation, employer's liability or similar law.

Affiliation Period

A period used by us in lieu of a pre-existing condition exclusion clause, beginning on the enrollment date, which must expire before coverage becomes effective. A Member is not eligible for health care benefits during this period.

Applicant

The corporation, partnership, sole proprietorship, other organization or Group which applied for this Contract.

Application for Enrollment

The original and any subsequent forms completed and signed by the Subscriber seeking coverage. Such Application may take the form of electronic submission.

Benefit Period

One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Brand Name Drug

A drug item which is under patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies. There are two types of Brand Name Drugs:

- Single Source Brand: Those drugs that are produced by only one manufacturer and do not have a generic equivalent available.
- Multi-Source Brand: Those drugs that are produced by multiple pharmaceutical manufactures and do have a generic equivalent available on the market.

Centers of Expertise (COE) Network

A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein members access select types of benefits through a specific network of medical centers.

The network of health care professionals that entered into contracts with Anthem, or one or more of its affiliates, to provide transplant or other designated specialty services.

Certificate

A short written statement which defines Anthem's legal obligation to the individual Members. It is part of this Certificate Booklet.

Chemical Dependency Treatment Facility

An institution established to care for and treat chemical dependency, on either an Inpatient or outpatient basis, under a prescribed treatment program. The institution must have diagnostic and therapeutic facilities for care and treatment provided by or under the supervision of a licensed Physician. The institution must be licensed, registered or approved by the appropriate authority of the State of Georgia or must be accredited by the Joint Commission on Accreditation of Hospitals.

Coinsurance

If a Member's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Limit.

Combined Limit

The maximum total of In-Network and Out-of-Network Benefits available for designated health service in the Summary of Benefits.

Complications of Pregnancy

Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Contract

This Certificate Booklet in conjunction with the Group Master Contract, the Group Master Contract Application, the Anthem Formulary, any amendment or rider, your Identification Card and your Application for Enrollment constitutes the entire Contract. If there is any conflict between either this Certificate Booklet or the Group Master Contract and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Certificate Booklet and the Group Master Contract, the Group Master Contract shall control.

Contract Year

A period of one year commencing on the Effective Date (or renewal date) and ending at 12:00 midnight on the last day of the one year period.

Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Cosmetic Surgery

Any non-medically necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty,

liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent

Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Certificate Booklet, has enrolled in the program, and is subject to Premium requirements set forth in the Group Master Contract.

Covered Services

Medically Necessary health care services and supplies that are (a) defined as Covered Services in the Member's Contract, (b) not excluded under such Contract, (c) not Experimental or Investigational and (d) provided in accordance with such Contract.

Creditable Coverage

Coverage under another health benefit program is medical expense coverage with no greater than a 90 day gap in coverage under any of the following: (a) Medicare or Medicaid; (b) an employer-based accident and sickness insurance or health benefit arrangement; (c) an individual accident and sickness insurance policy; (d) a spouse's benefits or coverage under Medicare or Medicaid or an employer-based health insurance benefit arrangement; (e) a conversion policy; or (f) similar coverage as defined in OCGA 33-30-15.

Custodial Care

Any type or care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of Anthem, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible

The portion of the bill you must pay before your medical expenses become Eligible Charges. It usually is applied on a calendar year basis.

Default Reimbursement Rate

The rate paid to any provider that does not participate in any of Anthem's networks (or any of its affiliates). The default reimbursement rate will never be greater than the reimbursement rate for any contracted provider.

Dependent

The spouse and all unmarried children until attaining age 19. Children include natural children, legally adopted children and stepchildren. Also included are your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree. Foster children whom you expect to raise to adulthood and who live with you in a regular parent-child relationship are considered children. However, for the purposes of this Contract, a parent-child relationship does not exist between you and a foster child if one or both of the child's natural parents also live with you. In addition, Anthem does not

consider as a Dependent, welfare placement of a foster child, as long as, the welfare agency provides all or part of the child's support.

Children who are full-time students (after high school) in an institution of higher learning at least five months each year remain covered up to and including age 25. Children up to and including age 25 that were required to withdraw enrollment from a post-secondary institution, prevented from enrollment, or required to reduce enrollment below the level required for full-time status as a result of an injury or illness shall be entitled to the same benefits as if the Dependent continued to be enrolled as a full-time student. Mentally retarded or physically handicapped children remain covered no matter what age. You must give Anthem evidence of your child's incapacity within 31 days of attainment of age 19. The certification form may be obtained from Anthem or your employer. This proof of incapacity may be required annually by Anthem. Such children are not eligible under this Contract if they are already 19 or older at the time coverage is effective.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay

The statistical variation as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury. Services rendered should be to treat or promote recovery of the specific functional deficits identified.

Direct Access

A Member has direct access to primary and specialty care directly from any In-network Physician. This is called Direct Access.

Drug Formulary

A document setting forth certain rules relating to the coverage of pharmaceuticals by Anthem, that may include but not be limited to (1) a listing of preferred prescription medications that are covered and/or prioritized in order of preference by Anthem, and are dispensed to Members through pharmacies that are Network Providers, and (2) pre-certification rules. This list is subject to periodic review and modification by Anthem, at its sole discretion. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Formulary.

Durable Medical Equipment

Equipment, as determined by Anthem, which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date

The date for which Anthem approves an individual application for coverage. For individuals who join this Group after the first enrollment period, the Effective Date is the date Anthem approves each future Member according to its normal procedures.

Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Eligible Charges

Those charges for services and supplies (a) defined as Covered Services and not excluded under the Member's Contract; (b) that are Medically Necessary; and (c) that are provided in accordance with the Member's Contract. Eligible Charges are determined by: (a) Anthem's Usual, Customary and Reasonable (UCR) Fees; (b) a provider's contracted fee schedule; (c) the applicable Reimbursement Rate; or (d) negotiated fees. All payment determinations for Hospital services are based on the applicable Reimbursement Rate. Reimbursement for Out-of-Network Providers is based on Eligible Charges for the type of service a Member receives, (for example, Hospital or Physician services).

Reimbursement for Non-Contracted Providers is determined by our Default Reimbursement Rate.

Employee

A person who is engaged in active employment with the Group and is eligible for Group coverage with Anthem under the employment regulations of the Group.

Experimental or Investigational

Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence. Medical and scientific evidence means:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t)(2) of the Social Security Act;
- The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
- It meets the Technology Assessment Criteria as determined by Anthem as outlined in the "Definitions" section of this Certificate Booklet.

Freestanding Ambulatory Facility

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis--no patients stay overnight. The facility offers continuous service by both Physicians and Registered Nurses (R.N.s). It must be licensed by the appropriate state agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Generic Drugs

Prescription Drugs that are not Brand Name Drugs but which are made of equivalent ingredients. Generic Drugs are just as effective as Brand Name Drugs, but are less costly.

Group

The Subscriber's employer, which has entered the Group Master Contract with Anthem. The Group shall act only as an agent of Members who are Subscribers of the Group and their Covered Dependents.

Home Health Care

Care, by a state-licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency

A provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate state agency.

Hospice

A provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate state agency.

Hospice Care Program

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate state agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital

An institution licensed by the appropriate state agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- An extended care facility; nursing home; place for rest; facility for care of the aged;
- A custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- An institution for exceptional or handicapped children.

Identification Card

The latest card given to you showing your member and Group numbers, the type coverage you have and the date coverage became effective.

Ineligible Charges

Charges for health care services that are not Eligible Charges because the services are not Medically Necessary or pre-admission certification was not obtained. Such charges are not eligible for payment.

Ineligible Hospital

A facility which does not meet the minimum requirements to become a Participating Hospital. Services rendered to a Member by such a Hospital are not eligible for payment.

Ineligible Provider

A provider which does not meet the minimum requirements to become a Participating Provider or with which Anthem does not directly contract. Services rendered to a Member by such a provider are not eligible for payment.

Infertile or Infertility

The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee

A person actively employed by the Group (or one of that person's Covered Dependents) on the original Effective Date of the Group Master Contract between Anthem and the Group or currently enrolled through the Group under an Anthem Contract.

Injury

Bodily harm from a non-occupational accident.

In-Network Care

Covered Services provided to Members by their Physician through Network Hospital and Network Providers. A Member has direct access to primary and specialty care directly from any In-Network Physician.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit

A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Late Enrollees

Late Enrollees means Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/hers initial enrollment period under the Contract; (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor covered Dependent under a Member's Contract, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to Anthem that coverage was declined because other coverage existed.

Lifetime Maximum Benefit

The Lifetime Maximum Benefit includes all payments made under this contract with Anthem. All services and all calendar year maximums, whether for a number of days or visits, treatments or a yearly dollar limit, are subject to the Lifetime Maximum Benefit.

Maternity Care

Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Contract.

MCSO-Medical Child Support Order

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

Medical Emergency

"Emergency services," "emergency care," or "Medical Emergency" means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are NOT limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and such other acute conditions as may be determined to be Medical Emergencies by Anthem.

Medical Facility

Any Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Certificate Booklet. The facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by Anthem.

Medical Necessity or Medically Necessary

Anthem reserves the right to determine whether a health care service or supply is Medically Necessary. The fact that a Physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary. Anthem considers a health care service Medically Necessary if it is:

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- compatible with the standards of acceptable medical practice in the United States;
- not provided solely for your convenience or the convenience of the Physician, health care provider or Hospital;
- not primarily Custodial Care; and
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

Member

The Subscriber and each Dependent, as defined in this booklet, while such person is covered by this Contract.

Mental Health Disorders

Includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and drug, alcohol or chemical dependency. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, chemical dependency disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Network Hospital

A Hospital located in Georgia which is a party to a written agreement with, and in a form approved by, Anthem to provide services to its Members; or a Hospital outside of Georgia which is a party to an agreement with another Blue Cross and Blue Shield HMO BLUE USA Plan.

Network Provider

A Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services and supplies in the Service Area that has a Network Provider Contract with us to provide Covered Services to Members. Also referred to as In-Network Provider.

New Hire

A person who is not employed by the Group on the original Effective Date of the Group Master Contract.

Non-Contracted Provider

A Hospital, Physician, Freestanding Ambulatory Facility, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have any Network agreement with Anthem to provide services to Members at the time services are rendered.

Non-Covered Services

Services that are not benefits specifically provided under the Contract, are excluded by the Contract, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Nurse Practitioner (NP)

An individual duly licensed by the State of Georgia to provide primary nursing and basic medical services.

Out-of-Network Care

Care received by a Member from an Out-of-Network Provider.

Out-of-Network Provider

A Hospital, Freestanding Ambulatory Facility (surgical center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have a PPO Network Provider Contract with Anthem.

Out-of-Pocket Limit

The maximum amount of a Member's Coinsurance payments during a given calendar year. Such amount does include Deductible but not amounts or charges in excess of providers' reasonable fees. When the Out-of-Pocket Limit is reached, the level of benefits is increased to 100% of Eligible Charges for Covered Services, exclusive other scheduled charges.

Participating Hospital

A Hospital located in Georgia which is a party to a written agreement with, and in a form approved by, Anthem; or a Hospital outside of Georgia which is a party to an agreement with a Blue Cross and Blue

Shield in another area; or a Hospital outside Georgia located in an area not served by a Blue Cross and/or Blue Shield plan.

Participating Provider

A Hospital, Physician, Freestanding Ambulatory Facility (Surgical Center), Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies that has signed a Participating Agreement with Anthem to accept its determination of the Usual, Customary and Reasonable Fee (UCR) or other payment provisions for Covered Services rendered to a Member who is his or her patient.

Periodic Health Assessment

A medical examination that provides for age-specific preventive services that improve the health and well-being of a patient being examined.

Physical Therapy

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor or Osteopathy (D.O.) approved by the Composite State Board of Medical Examiners, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (Ph.D.) are also providers when acting within the scope of their licenses, and when rendering services covered under this Contract.

Physician Assistant (PA)

An individual duly licensed by the State of Georgia to provide basic medical services under the supervision of a licensed physician.

Physician Assistant Anesthetist (PAA)

An individual duly licensed by the State of Georgia to provide anesthesia services under the supervision of a licensed physician specializing in anesthesia.

Plan Administrator

The person named by your employer to manage the program and answer questions about program details.

Premium

The amount that the Group or Member is required to pay Anthem to continue coverage.

Prescription Drug

A drug which cannot be purchased except with a prescription from a Physician.

Primary Care Physician (PCP)

A licensed Physician who is a Participating Provider trained in general family practice, pediatrics or internal medicine, and has entered into an agreement to coordinate the care of Members. Your Primary Care Physician provides initial care and basic medical services, assists you in obtaining pre-certification of Medically Necessary Referrals for Specialist and Hospital care, and provides you with continuity of care.

Professional Ambulance Service

A state-licensed emergency vehicle which carries via the public streets injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Provider

Any physician, health care practitioner, pharmacy, supplier or facility, including, but not limited to, a hospital, clinical laboratory, freestanding ambulatory surgery facility, skilled nursing facility, long term acute care facility, or home health care agency holding all licenses required by law in the State of Georgia to provide health care services.

Psychiatric Services within a General Hospital Facility

A general hospital facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

QMCSO – Qualified Medical Child Support Order

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

Referral

Specific instructions from a Member's Physician, in conformance with our policies and procedures, that direct a Member to an In-Network Provider for Medically Necessary care.

Reimbursement Rate

Eligible Charges calculated each year by Anthem for any contracted Provider. The payment rate will be applied to all provider claims during the payment period.

Respite Care

Care furnished during a period of time when the Member's family or usual caretaker cannot, or will not, attend to the Member's needs.

Semiprivate Room

A Hospital room which contains two or more beds.

Service Area

Includes counties listed in the appropriate Service Area map. (Please refer to your Provider Directory.)

Similar Drugs

Similar Drugs are those within a certain therapeutic class such as insomnia drugs, oral contraceptives, seizure drugs, etc.

Skilled Convalescent Care

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility

An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate state agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by Anthem to meet the reasonable standards applied by any of the aforesaid authorities.

Specialty Drugs

Typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require preauthorization to be considered Medically Necessary.

Specialty Pharmacy

A pharmacy which dispenses biotech drugs for rare and chronic diseases via scheduled drug delivery either to the Member's home or to a Physician's office. These pharmacies also provide telephonic therapy management to ensure safety and compliance.

Subscriber

The individual who signed the Application for Enrollment and in whose name the Identification Card is issued.

Substance Abuse

Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Substance Abuse Rehabilitation

Services, procedures and interventions to eliminate dependence on or abuse of legal and/or illegal chemical substances, according to individual treatment plans.

Substance Abuse Residential Treatment Center

A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

Substance Abuse Services within a General Hospital Facility

A general hospital facility that provides services, on an inpatient, 24-hour basis, for medical detoxification and treatment of conditions associated with the addiction to or misuse of alcohol or other drugs.

Technology Assessment Criteria

Five criteria all investigative procedures must meet in order to be Covered Services under this Contract.

- The technology must have final approval from the appropriate government regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology of health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternative.
- The technology must be beneficial in practice.

Telehealth Services

A health care service, other than a telemedicine service, delivered by a licensed or certified health professional, acting within the scope of the healthcare professional's license or certification, who does not perform a telemedicine medical service, that requires the use of advanced telecommunications technology, other than by telephone or facsimile including:

- Compressed digital interactive video, audio, or data transmission.
- Clinical data transmission using computer imaging by way of still-image capture; and,
- Other technology that facilitates access to healthcare services or medical specialty expertise.

Telemedicine Medical Service

A health care medical service initiated by a physician or provided by a health care professional, diagnosis, treatment or consultation by a physician, or the transfer of medical data that requires the use of advance communications technology, other than by telephone or facsimile including:

- Compressed digital interactive video, audio, or data transmission.
- Clinical data transmission using computer imaging by way of still-image capture; and,
- Other technology that facilitates access to healthcare services or medical specialty expertise.

Neither a telephone conversation nor an electronic mail message between a healthcare practitioner and a patient is telemedicine.

Therapeutic / Clinically Equivalent

Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. "Clinically / Therapeutic equivalent" means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. Therapeutic / Clinically Equivalent determinations are based on industry standards and reviewed by such organizations as The Agency for Healthcare Research and Quality (AHRQ), a division of the U.S. Department of Health and Human Services.

Urgent Care

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an emergency. Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. Benefits provided for Urgent Care Services are outlined in the **Summary of Benefits**.

Urgent Care Center

A facility, appropriately licensed and meeting Anthem standards for an Urgent Care Center, with a staff of Physicians and health care professionals that is organizationally separate from a Hospital and whose primary purpose is providing urgently needed medical procedures. Services are performed on an outpatient-basis and no patients stay overnight. A Physician's office does not qualify as an Urgent Care Center.

Usual-Customary-Reasonable (UCR) Fees (as determined by Anthem):

Usual Fee: The fee a Physician most frequently receives as reimbursement for the procedure performed.

Customary Fee: Based on a competitive profile of the usual fees received as reimbursement by similar Physicians in a given geographic area for the procedure performed, according to Anthem's records.

Reasonable Fee: The fee different from usual or customary fees because of unusual circumstances involving complications requiring additional time, skill and experience.

If it does not pay at contracted rates, Anthem may pay up to the usual fee not to exceed the customary fee, unless special circumstances or complications occur, in which case Anthem may consider the reasonable fee.

All payments are based on the UCR applicable to the Member's actual residence (i.e., local UCR).

Utilization Review

A function performed by Anthem or by an organization or entity selected by Anthem to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, outpatient care or diagnostic services are appropriate.

Statement of ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other Employees, ERISA imposes duties on the people responsible for the operation of your Employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to \$110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Claims Disclosure Notice

This Certificate Booklet contains information on reporting claims, including the time limitations on submitting a claim. Claim forms may be obtained from the Plan Administrator or Anthem. In addition to this information, if this *plan* is subject to ERISA, ERISA applies some additional claim procedure rules. The additional rules required by ERISA are set forth below. To the extent that the ERISA claim procedure rules are more beneficial to you, they will apply in place of any similar claim procedure rules included in this Certificate Booklet.

Urgent Care. Anthem must notify you, within 72 hours after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If your request for benefits does not contain all the necessary information, Anthem must notify you within 24 hours after receiving it and tell you what information is missing. Any notice to you by Anthem will be orally by telephone or in writing by facsimile or other fast means. You have at least 48 hours to give Anthem the additional information needed to process your request for benefits. You may give Anthem the additional information needed orally by telephone or in writing by facsimile or other fast means.

Anthem Lumenos HSA

If your request for benefits is denied in whole or in part, you will receive a notice of the denial within 72 hours after Anthem's receipt of the request for benefits or 48 hours after receipt of all the information needed to process your request for benefits, if the information is received in a timely manner as stated above. The notice will explain the reason for the denial and the plan provision upon which the decision is based. You have 180 days to appeal the decision. You may appeal the decision orally by telephone or in writing by facsimile or other fast means. Within 72 hours after Anthem receives your appeal, if your claim is still considered urgent under the circumstances at the time of the appeal, Anthem must notify you of the decision. Anthem will notify you orally by telephone or in writing by facsimile or other fast means. If your claim is no longer considered urgent, it will be handled in the same manner as a Non-Urgent Care Pre-Service or Post-Service appeal, depending upon the circumstances.

Non-Urgent Care Pre-Service (when care has not yet been received). Anthem must notify you, within 15 days after receiving your request for benefits, that the request has been received and what your benefits are determined to be. If Anthem needs more than 15 days to determine your benefits, due to reasons beyond Anthem's control, Anthem must notify you within that 15 days period that more time is needed to determine your benefits. But, in any case, even with an extension, Anthem cannot take more than 30 days to determine your benefits. If you do not properly submit all the necessary information for your claim, Anthem must notify you, within 5 days after receiving it and tell you what information is missing. You have 45 days to provide Anthem with the information needed to process your request for benefits. The time period during which Anthem is waiting for receipt of the necessary information is not counted toward the time frame in which Anthem must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the denial within the time frame noted above after Anthem has all the information needed to process your request for benefits, if the information is received in a timely manner as stated above. The written notice will explain the reason for the denial and the plan provisions upon which the decision was made. You have 180 days to appeal an adverse benefit determination. Your appeal must be in writing. Within 30 days after a pre-service appeal is received, anthem must notify you of the decision. Anthem's notice of the decision will be in writing.

Concurrent Care Decisions. If, after approving a request for benefits in connection with your illness or Injury, Anthem decides to reduce or end the benefits that had been approved for you, in whole or in part:

- Anthem must notify you sufficiently in advance of the reduction in benefits, or the end of benefits, to allow you the opportunity to appeal the decision before the reduction in benefits or end of benefits occurs. In the notice to you, Anthem must explain the reason for reducing or ending your benefits and the plan provisions upon which the decision was made.
- To keep the benefits you already have approved, you must successfully appeal the decision to reduce or end those benefits. You must make your appeal to Anthem at least 24 hours prior to the occurrence of the reduction or ending of benefits. If you appeal the decision to reduce or end your benefits when there is less than 24 hours to the occurrence of the reduction or ending of benefits, your appeal will be treated as if you were appealing a non-urgent care denial of benefits (see "Urgent Care" above).
- If your appeal for benefits is received at least 24 hours prior to the occurrence of the reduction or ending of benefits, Anthem must notify you of the decision regarding your appeal within 72 hours of the receipt of your appeal. If your appeal of the decision to reduce or end your benefits is denied, in whole or in part, Anthem must explain the reason for the denial of benefits and the plan provisions upon which the decision was made. You may further appeal the denial of benefits according to the rules for appeal of an urgent care denial of benefits (see "Urgent Care" above).

Anthem Lumenos HSA

Non - Urgent Care Post-Service (reimbursement for cost of medical care). Anthem must notify you, within 30-days after receiving your request for benefits, that the request has been received and what your benefits are determined to be. (In order to comply with Georgia law, Anthem will address claims for services already rendered within 15 business days of receipt.) If more than 30 days are needed to determine your benefits, due to reasons beyond Anthem's control, Anthem must notify you within that 30-day period that more time is needed to determine your benefits. But, in any case, even with an extension, Anthem cannot take more than 45 days to determine your benefits. If you do not submit all the necessary information for your claim, Anthem must notify you, within 30 days after receiving it and tell you what information is missing. You have 45 days to provide the information needed to process your claim. The time period during which Anthem is waiting for receipt of the necessary information is not counted toward the time frame in which Anthem must make the benefit determination.

If your claim is denied in whole or in part, you will receive a written notice of the adverse benefit determination within the time frame stated above after Anthem has all the information needed to process your request for benefits, if the information is received within the time frame noted above. The written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the decision was made. You have 180 days to appeal the adverse benefit determination. Your appeal must be in writing. Within 60 days after receiving your appeal, Anthem must notify you of the decision. The notice to you of the decision will be in writing.

Note: You, your beneficiary, or a duly authorized representative may appeal any denial of a claim for benefits with Anthem and request a review of the adverse benefit determination. In connection with such a request, documents pertinent to the administration of the plan may be reviewed free of charge; and issues outlining the basis of the appeal may be submitted. You may have representation throughout the appeal and review procedure.

Medical information Anthem has regarding your case will be released to you or an attorney only by written authorization from your provider and/or the Hospital.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate lifetime limits, calendar year dollar limits, and treatment limitations (day or visit limits) on mental health and substance abuse benefits with dollar limits or day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set calendar year dollar limits, lifetime dollar limits, or day/visit limits on mental health or substance abuse benefits that are lower than any such dollar limits or day/visit limits for medical and surgical benefits. A plan that does not impose calendar year dollar limits, lifetime dollar limits, or day/visit limits on medical and surgical benefits may not impose such dollar limits or day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Statement of Rights Under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. **See the Summary of Benefits.**

If you would like more information on WHCRA benefits, call your Plan Administrator.

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Anthem Lumenos HSA

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