

Medicomp Three Benefit Booklet

The State of New Hampshire Health Plan
For Over 65 Retirees or Retirees on Medicare Parts A & B
Due to Disability



What You Need to Know about Your Health Care Plan



**Anthem Blue Cross and Blue Shield is located at
3000 Goffs Falls Road, Manchester, New Hampshire 03111-0001
Anthem's toll-free telephone number is 1-800-933-8415**

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.

Welcome!

Anthem Blue Cross and Blue Shield (Anthem) welcomes you to Anthem's family of members. Anthem thanks you for choosing Anthem to be the administrator of your managed health care Plan.

Please contact Anthem whenever you have questions, concerns or suggestions. Anthem's Customer Service Representatives are available during business hours to assist you. A representative will ask for the identification number listed on your identification card so that Anthem can locate your important records and assist you without delay.

Please call Anthem at 1-800-933-8415. You can contact Anthem as follows:

Type of Communication	Mail to
Inquiries - Benefit questions or claims status	Anthem Blue Cross and Blue Shield P.O. Box 660 North Haven, Connecticut 06473-0660
Appeals - Review of claims decision	Anthem Blue Cross and Blue Shield P.O. Box 518 North Haven, Connecticut 06473-0518
Claims - Submission of claims for processing	Anthem Blue Cross and Blue Shield P.O. Box 533 North Haven, Connecticut 06473-0533
You can visit Anthem at	Anthem Blue Cross and Blue Shield 3000 Goffs Falls Road Manchester, New Hampshire

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



Douglas J. Wenners
President and General Manager
New Hampshire

This product is administered by Anthem Health Plans of New Hampshire, Inc., operating as Anthem Blue Cross and Blue Shield (Anthem).

Anthem is licensed in the State of New Hampshire as a third party administrator. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. The State of New Hampshire assumes responsibility for funding of claims.

Anthem is an independent licensee of the Blue Cross and Blue Shield Association.

Table of Contents

Cost Sharing Schedule	7
Section 1 Overview How Your Plan Works –General Information	10
I. About This Benefit Booklet	10
II. Anthem Participating Providers	10
III. Group Coverage Arranged by the State of New Hampshire	11
IV. Services Must Be Medically Necessary	11
V. No Preexisting Condition Exclusion	11
Section 2 Cost Sharing Terms	12
Section 3 Anthem Participating Providers	13
Section 4 Nonparticipating Providers	14
Section 5 About Managed Care	15
Section 6 Emergency Care and Urgent Care	17
I. Urgent Care	17
II. Emergency Care	17
III. Emergency Room Visits for Emergency Care	17
IV. Inpatient Admissions to a Hospital for Emergency Care	17
Section 7 Covered Services	18
I. Inpatient Services	18
A. Care in a Short Term General Hospital	18
B. Care in a Skilled Nursing Facility or Physical Rehabilitation Facility	19
C. Inpatient Physician and Professional Services	19
II. Outpatient Services	19
A. Preventive Care	19
B. Medical/Surgical Care in a Physician’s Office	20
C. Outpatient Facility Care in the Outpatient Department of a Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center	21
D. Emergency Room Visits for Emergency Care	22
E. Ambulance Services	22
III. Outpatient Physical Rehabilitation Services	22
A. Physical Therapy, Occupational Therapy and Speech Therapy	22
B. Cardiac Rehabilitation	23
C. Chiropractic Care	23
D. Cognitive Rehabilitation	24
E. Pulmonary Rehabilitation	24
IV. Home Care	24
A. Physician Services	24
B. Home Health Agency Services	24
C. Hospice	24
D. Infusion Therapy	25
E. Durable Medical Equipment, Medical Supplies and Prosthetics	25

V. Behavioral Health Care	30
A. Access to Behavioral Health Care	30
B. Covered Behavioral Health Care Services	30
C. Eligible Behavioral Health Providers	31
D. Criteria for Coverage.....	33
E. Exclusions.....	33
VI. Important Information About Other Covered Services	34
A. Dental Services	34
B. Hearing Services.....	37
C. Infertility Diagnostic Services	37
D. Organ and Tissue Transplants	39
E. Qualified Clinical Trials: Routine Patient Care	41
F. Required Exams or Services	42
G. Surgery	42
H. Vision Services	45
Section 8 Limitations and Exclusions	46
I. Limitations	46
A. Private Room.....	46
B. Ultraviolet Light Therapy and Ultraviolet Laser Therapy for Skin Disorders	46
II. Exclusions	47
Alternative Medicine or Complementary Medicine	47
Amounts that Exceed the Maximum Allowable Benefit	47
Artificial Insemination	47
Biofeedback Services	47
Blood and Blood Products	47
Care Furnished by a Family Member	48
Care Received When you are not Covered Under this Benefit Booklet.....	48
Care or Complications Related To Noncovered Services	48
Chelating Agents.....	48
Contraceptive Services.....	48
Convenience Services	48
Cosmetic Services	49
Custodial Care.....	49
Disease or Injury Sustained as a Result of War or Participation in a Riot or Civil Disobedience	50
Domiciliary Care.....	50
Educational, Instructional, Vocational Services and Developmental Disability Services.....	50
Experimental/Investigational Services	50
Food and Food Supplements	51
Foot Care (Routine), Foot Orthotics and Therapeutic/Corrective Shoes.....	51
Free Care	52
Government Programs	52
Home Test Kits	52
Missed Appointments	52
Non-Hospital Institutions	52
Nonmember Biological Parents.....	52
Pharmacy Services	52
Premarital Laboratory Work	52
Private Duty Nurse.....	52
Processing Fees.....	52

Rehabilitation Services	52
Reversal of Voluntary Sterilization.....	52
Sclerotherapy for Varicose Veins and Treatment of Spider Veins.....	53
Services Not Covered and Care Related to Noncovered Services	53
Sex Change Treatment.....	53
Smoking Cessation Drugs, Programs or Services	53
Surrogate Parenting.....	53
Transportation	53
Weight Control.....	53
Workers' Compensation.....	53
X-rays.....	54
Section 9 Claim Procedure.....	55
I. Post-Service Claims	55
II. Pre-Service	55
III. Notice of a Claim Denial.....	57
IV. Appeals	57
V. General Claims Processing Information	57
Section 10 Other Party Liability.....	59
I. Coordination of Benefits (COB)	59
II. Definitions	60
III. The Order of Payment is Determined by COB.....	61
IV. Workers' Compensation.....	62
V. Subrogation and Reimbursement.....	62
VI. Anthem's Rights Under this Section	64
VII. Your Agreement and Responsibility Under this Section	65
Section 11 Member Satisfaction Services and Appeal Procedure	66
I. Member Satisfaction Services.....	66
II. Internal Appeal Procedure	67
III. Voluntary External Review	70
IV. Disagreement With Recommended Treatment.....	71
V. Appeal Outcomes	71
Section 12 General Provisions	72
Section 13 Membership Eligibility, Termination of Coverage and Continuation of Group Coverage	74
I. Eligibility	74
II. Termination of Coverage.....	76
III. Continuation of Group Coverage	77
Section 14 Definitions	80
Adverse Determination.....	80
Anthem.....	80
Anthem Participating Birthing Center.....	80
Anthem Participating Diabetes Education Provider	80
Anthem Participating Nutrition Counselor.....	80
Anthem Participating Provider.....	80
Behavioral Health Care	80
Benefit Booklet	80
Benefits	80
Birthing Center.....	80
BlueCard Provider.....	80

Calendar Year.....	80
Claim Denial	80
Contracting Provider	81
Convenience Services	81
Covered Service	81
Designated Provider	81
Developmental Disabilities	82
Home Health Agency	82
Inpatient	82
Local Plan	82
Maximum Allowable Benefit	82
Medical Director	82
Medically Necessary or “Medical Necessity”	82
Medicare.....	83
Medicare Assignment.....	83
Member	83
NonBlueCard Provider.....	83
Nonparticipating Provider	83
Outpatient.....	83
Physical Rehabilitation Facility.....	83
Plan	83
Post-Service Claims	83
Precertification or Precertify	83
Pre-Service Claim	83
Prior Approval.....	83
Retiree	83
Service Area.....	83
Short Term General Hospital.....	83
Skilled Nursing Facility.....	84
Subcontractor	84
Subscriber.....	84
Urgent Care Claim	84
You and Your.....	84

Medicomp Three Cost Sharing Schedule

This Cost Sharing Schedule describes your cost sharing requirements and Benefits. Do not rely on this outline alone. Please read your Benefit Booklet carefully, because important terms and limitations apply.

This health care plan is specifically intended for individuals enrolled in Medicare Parts A and B. Coverage under this plan is Secondary to Medicare.

Medical/Surgical Care	Your Cost Benefits under this plan are Secondary to Medicare †
I. Inpatient Services	
in a Short Term General Hospital (facility charges for medical, surgical and maternity admissions)	You pay \$0
in a Skilled Nursing Facility or Physical Rehabilitation Facility (facility charges) up to a combined 100 Inpatient days per Calendar Year	
Inpatient physician and professional services such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests <i>For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.</i>	
II. Outpatient Services	
Preventive Care	
immunizations (including travel and rabies immunizations)	You pay \$0
mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening	
routine physical exams (including one annual gynecological exam) family planning visits	
nutrition counseling - limited to three visits each Calendar Year (this limit does not apply to diabetes and organic illnesses).	
diabetes management program	
Medical/Surgical Care in a Physician's Office (in addition to the Preventive Care above)	
medical exams, consultations, office surgery and anesthesia, injections (including allergy injections), allergy serum dispensed by the physician, medical treatments	You pay \$0
laboratory and x-ray tests (including allergy testing and ultrasound)	
MRA, MRI, PET, SPECT, CT Scan, CTA chemotherapy, medical supplies and drugs	
maternity care (prenatal and postpartum visits) Please see Section 7 "Covered Services" of this Benefit Booklet for complete information about total maternity care.	You pay \$0
Also, see III, "Outpatient Physical Rehabilitation Services" (below)	

† Benefits are limited to the Maximum Allowable Benefit (MAB). Anthem Participating Providers agree to accept the Maximum Allowable Benefit as payment in full. If you receive Covered Services from a Nonparticipating Provider, you may be responsible for paying the difference between the Maximum Allowable Benefit and the provider's charge.

Outpatient Facility Care: in the Outpatient Department of a Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center (This is in addition to the Preventive Care above. Also see “Emergency Care and Urgent Care” below.)	Your Cost Benefits under this plan are Secondary to Medicare †
medical exams and consultations by a physician	You pay \$0
operating room for surgery or delivery of a baby	
physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy	
hemodialysis, chemotherapy, radiation therapy, infusion therapy, MRA, MRI, PET, SPECT, CT Scan, CTA	
facility charges, medical supplies, drugs, other ancillaries, observation	
laboratory and x-ray tests (including ultrasounds)	
Also, see III, “Outpatient Physical Rehabilitation Services” (below)	
Emergency Care and Urgent Care - Emergency Room Visits and Urgent Care Facility Visits	
use of the emergency room	You pay \$0
emergency room physician’s fee, surgery, MRA, MRI, PET, SPECT, CT Scan, CTA, medical supplies and drugs	
laboratory and x-ray tests	
Ambulance Services Transport by ambulance must be Medically Necessary.	
III. Outpatient Physical Rehabilitation Services	
The following services are limited to a combined maximum of 60 visits each Calendar Year: <ul style="list-style-type: none"> • Physical Therapy, Occupational Therapy, and Speech Therapy • Pulmonary Therapy • Cognitive Therapy • Cardiac Rehabilitation Visits • Chiropractic Visits 	You pay \$0
IV. Home Care (in addition to the Preventative Care listed in subsection II above)	
Physician services medical exams and routine physical exams, injections, medical treatments, surgery and anesthesia	You pay \$0
Home Health Agency services	
Hospice	
Infusion Therapy	
Durable Medical Equipment, Medical Supplies and Prosthetics	

† Benefits are limited to the Maximum Allowable Benefit (MAB). Anthem Participating Providers agree to accept the Maximum Allowable Benefit as payment in full. If you receive Covered Services from a Nonparticipating Provider, you may be responsible for paying the difference between the Maximum Allowable Benefit and the provider’s charge.

V. Behavioral Health Care (Mental Health and Substance Abuse Care)	
Outpatient/office visits	
Mental Health visits - Medically Necessary visits <ul style="list-style-type: none"> • Individual therapy • Group therapy • Intensive Outpatient Treatment Programs (IOP) 	You pay \$0
Substance Abuse visits - <i>Medically Necessary visits. Benefits are limited to a combined maximum of \$5,000 per Calendar Year and \$10,000 lifetime**</i> <ul style="list-style-type: none"> • Individual therapy • Group therapy • Intensive Outpatient Treatment Programs (IOP) 	
Inpatient Care	
You must call Anthem for Precertification. Please call 1-800-228-5975 for Precertification. See Section 7 in this Benefit Booklet for details.	
Mental Disorders - Medically Necessary days <ul style="list-style-type: none"> • Inpatient • Partial Hospitalization Programs (PHP) 	You pay \$0
Substance Abuse Conditions - <i>Medically Necessary days. Benefits are limited to a combined maximum of \$5,000 per Calendar Year and \$10,000 lifetime**</i> <ul style="list-style-type: none"> • Inpatient (including medical detoxification and substance abuse rehabilitation) • Partial Hospitalization Program (PHP) 	
Scheduled Ambulance Transport limited to Medically Necessary transport from one facility to another	

† Benefits are limited to the Maximum Allowable Benefit (MAB). Anthem Participating Providers agree to accept the Maximum Allowable Benefit as payment in full. If you receive Covered Services from a Nonparticipating Provider, you may be responsible for paying the difference between the Maximum Allowable Benefit and the provider's charge.

** Major Medical is a supplement to your Medcomp coverage. Under Major medical, Inpatient and Outpatient (combined) substance abuse Benefits are limited to a maximum of \$5,000 per Calendar Year and \$10,000 lifetime.

Section 1: Overview – How Your Plan Works

Please see Section 14 for definitions of specially capitalized words.

This health care plan is specifically intended for individuals enrolled in Medicare Parts A and B. As a retiree of the State of New Hampshire, coverage under this plan is Secondary to Medicare.

Benefits are available for Covered Services which are paid or payable by Medicare. Covered Services are determined based upon policies and rules published by Medicare.

I. About This Benefit Booklet

This is your Medcomp Three Benefit Booklet. It describes the relationship among you, your health care provider, the State of New Hampshire and Anthem. You are entitled to the Benefits described in this Benefit Booklet provided that all conditions for membership described in Section 13, I, “Eligibility” have been met. Certain rights and responsibilities are also described in this Benefit Booklet.

Your Cost Sharing Schedule is an Important Part of this Benefit Booklet. It provides a summary of your Benefits and lists certain limitations. The State of New Hampshire may issue riders or endorsements that amend this Benefit Booklet by describing additional Covered Services or limitations. Please read your Benefit Booklet carefully because it explains the terms of your coverage.

II. Anthem Participating Providers

For purposes of Medicare benefits, providers elect to accept or not accept Medicare Assignment. To receive the maximum level of Medicare benefits, you need to use a provider who accepts Medicare Assignment.

Anthem Participating Providers are physicians, specialists, hospitals and other health care providers and facilities that have a payment agreement directly with Anthem Health Plans of New Hampshire, Inc., (Anthem) to provide Covered Services to Members. Anthem Participating Providers are listed in the Participating Provider Directory. Since the printed directory is updated periodically, your directory book may not always be current at the time you need to arrange for Covered Services. To locate the most up-to-date information about Anthem Participating Providers, please go to Anthem’s website, www.anthem.com. Or, you may contact Anthem’s Customer Service for assistance. The toll-free telephone number is on your identification card.

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

Payment agreements may include financial incentives or risk sharing relationships related to provision of services to Nonparticipating Providers and disease management programs. Financial incentives for cost-effective care are consistent with generally recognized professional standards. If you have questions regarding such incentives or risk sharing relationships, please contact your provider or Anthem.

Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Subcontractors may include but are not limited to prescription drugs and/or Behavioral Health Care. Such subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, network management or customer service duties on Anthem’s behalf.

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

Physicians, hospitals, facilities and other providers who are not Anthem Participating Providers are Nonparticipating Providers.

III. Group Coverage Arranged by the State of New Hampshire

You are covered under this Benefit Booklet as part of the State of New Hampshire's retiree health care plan. The State of New Hampshire and Anthem determine eligibility rules. The State of New Hampshire acts on your behalf by sending to Anthem the premium to maintain your coverage. By completing the enrollment process and enrolling in this health plan, you authorize the State of New Hampshire to make premium payments to Anthem on your behalf, and you agree to the terms of this Benefit Booklet. Provided that the required premium is paid on time, your coverage becomes effective on a date determined by the State of New Hampshire and by Anthem, and as required by law.

IV. Services Must be Medically Necessary

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

Anthem may review services after they have been furnished in order to confirm that they were Medically Necessary. Unless you sign an agreement with the provider accepting responsibility for services that are not Medically Necessary, Anthem Participating Providers are prohibited from billing you for care that is not Medically Necessary, provided that the services would have been covered had they been Medically Necessary. For the services of a Nonparticipating Provider, you are responsible for paying the full cost of services that are not Medically Necessary.

Note: Medicare and Anthem may have different policies or rules that are used to determine whether services you receive are Medically Necessary. Medicare's Medical Necessity policies and rules are used to determine whether services are paid or payable under Medicare Part A or Part B and are eligible for Medicare.

V. No Preexisting Condition Exclusion

The coverage provided by the State of New Hampshire does not apply or enforce any preexisting condition exclusions with respect to your coverage under the Plan.

Section 2: Cost Sharing Terms

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

Benefits generally satisfy those amounts that remain after Medicare has made payment for Medicare Eligible Expenses, for example Medicare Part A and Part B Deductibles and Medicare Coinsurance. If you exhaust or exceed any Medicare limitations or maximums or you incur expenses for services that are not Medicare Eligible Expenses, you may be entitled to Benefits as described in this Benefit Booklet.

Under this health care plan, you may be responsible for the cost of certain Covered Services.

A. Certain annual coverage limitations may apply under this Plan. Annual coverage limitations apply to certain Covered Services, as stated on your Cost Sharing Schedule and in this Benefit Booklet. For example, Benefits for Outpatient physical rehabilitation or Behavioral Health Care may be limited to calendar year maximums. You are responsible for the cost of services that exceed an annual coverage limitation.

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

Amounts that exceed the Maximum Allowable Benefit do not count toward meeting any cost sharing requirements or other out-of-pocket costs.

Anthem Participating Providers and BlueCard Providers agree to accept the Maximum Allowable Benefit as payment in full. You are responsible for paying the difference between the Maximum Allowable Benefit and the provider's charge when you receive Covered Services from a Nonparticipating New Hampshire Provider or a NonBlueCard Provider outside New Hampshire.

Note: for purposes of Medicare benefits, providers elect to accept or not accept Medicare Assignment. To receive the maximum level of Medicare benefits, you need to use a provider who accepts Medicare Assignment.

C. Noncovered or Excluded Services. You are responsible for paying the full cost of any service that is not described as a Covered Service in this Benefit Booklet. You are responsible for paying the full cost of any service that is excluded from coverage in this Benefit Booklet. This applies even if your physician or other provider prescribes, orders or furnishes the service and even if the service meets Anthem's definition of Medical Necessity.

Section 3: Anthem Participating Providers

Please see Section 14 for definitions of specially capitalized words.

I. Introduction

Under this health care plan, Participating Providers are called Anthem Participating Providers. When your care is furnished by an Anthem Participating Provider, you enjoy the following advantages:

- You do not have to pay the difference between the Maximum Allowable Benefit and the Provider's charge. Anthem Participating Providers agree to accept the Maximum Allowable Benefit as payment in full.
- The Maximum Allowable Benefit is determined as defined in Section 14 "Definitions" of this Benefit Booklet.
- You do not have to file claim forms or manage the payment of Benefits to your provider. Anthem Participating Providers will submit claim forms for you.
- Anthem pays Benefits directly to Anthem Participating Providers.

Note: Physicians, hospitals, facilities and other providers who are not Anthem Participating Providers are Nonparticipating Providers. Please see Section 4, "Nonparticipating Providers" for important information about NonParticipation Providers.

II. About Anthem Participating Providers

Anthem's network of Participating Providers include, but is not limited to, the following provider types:

- Physicians
- Specialists
- Hospitals
- Other health care providers, and
- Facilities (skilled nursing, physical rehabilitation, etc)

Anthem Participating providers have a payment agreement directly with Anthem to provide Covered Services to Members.

Anthem Participating Providers are listed in the Provider Directory. The printed directory is updated periodically and may not always be current at the time you need to arrange for Covered Services. **To locate the most up-to-date information about Anthem Participating Providers, please go to Anthem's website, www.anthem.com. Or, you may contact Customer Service for assistance. The toll-free telephone number is on your identification card.**

Section 4: Nonparticipating Providers

Please see Section 14 for definitions of specially capitalized words.

You have the freedom to seek Covered Services from Nonparticipating Providers. Under this health care plan, providers that do not have a payment agreement with Anthem to provide Covered Services to members are called Nonparticipating Providers. When your care is furnished by a Nonparticipating Provider, please remember the following:

- Nonparticipating Providers are not required to accept the Maximum Allowable Benefit as payment in full.
- You are responsible for paying the difference between the Maximum Allowable Benefit and the Provider's charge.
- The Maximum Allowable Benefit is determined as defined in Section 14 "Definitions" of this Benefit Booklet.
- You may be required to file claim forms or manage the payment of Benefits to your provider.
- Nonparticipating Providers are not required to submit claim forms for you.
- Anthem may pay Benefits directly to the Subscriber.

Note: please see Section 9 "Claim Procedure" for important information about traveling outside of the country.

Section 5: About Managed Care

Please see Section 14 for definitions of specially capitalized words.

Each service that you receive must be Medically Necessary, otherwise, no Benefits are available. Medicare and Anthem may have different policies or rules that are used to determine whether services you receive are Medically Necessary. Medicare's Medical Necessity policies and rules are used to determine whether services are paid or payable under Medicare Part A or Part B.

If services fall outside secondary benefits, then this plan applies the managed care rules listed in this section.

This means that when you receive certain Covered Services, Anthem (or a designated administrator) works with you and your health care providers to determine that your Covered Services are Medically Necessary as defined in Section 14 of this benefit Booklet.

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

"Precertification" is the process used by Anthem to review services proposed by Anthem Participating Providers to determine if the service meets Anthem's definition of Medical Necessity and is delivered in the most appropriate health care setting. The definition of "Medical Necessity" is stated in Section 14. Your provider's orders and/or Anthem's Precertification does not guarantee coverage for or the payment of the service or procedure reviewed. Benefits are subject to the terms, limitations and conditions stated in this Benefit Booklet. For example, your coverage for Benefits is subject to the eligibility rules stated in Section 13.

Anthem plays an important role in the administration of your Benefits. Some examples are:

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

B. Determinations about Medical Necessity. Anthem is given the right to make determinations about whether or not a service is Medically Necessary. Please see Section 12 for a definition of "Medically Necessary."

Please note: Anthem's Medical Policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of Medical Policy is to assist in Anthem's determination of Medical Necessity. However, the Benefits, exclusions and limitations take precedence over Medical Policy. Medical technology is constantly changing and Anthem reserves the right to review and update Medical Policy periodically.

C. Determinations about Experimental or Investigational Services. Anthem is given the right to make determinations about whether or not a service is Experimental or Investigational. Please see Section 6, I, "Experimental/Investigational Procedures and Qualified Clinical Trials" for complete information.

D. Review of New Technologies. Anthem is given the right to make final determinations about coverage for new technologies. Anthem evaluates new medical technologies to define medical efficacy and to determine appropriate coverage. Anthem's evaluations are focused on the following factors:

- The technology must have final approval from the appropriate governmental regulatory bodies.

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve net health outcomes.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the Investigational setting.

E. Care Management Programs. Anthem maintains care management and proactive care management programs that tailor services to the individual needs of Members and seek to improve the health of Members. Participation in the care management programs is entirely voluntary. Care managers are registered nurses and other qualified health professionals who work collaboratively with Members, their families, and providers to coordinate Members' Benefits.

Any Member, a Member's family members, or the Member's provider can request an assessment for participation in the care management programs by calling **1-800-422-2940**. Care management program services may be appropriate for a number of circumstances, including the following:

- If you have an acute or chronic illness requiring frequent hospitalization, home care services or ongoing treatment
- If you have experienced a catastrophic illness or injury

In extraordinary circumstances involving care management program services, Anthem is given the right to provide Benefits for alternate care that is not listed as a Benefit under this Benefit Booklet. Anthem also is given the right to extend Covered Services beyond the Benefits provided under this Benefit Booklet. Decisions are made by the Plan on a case-by-case basis dependent upon the unique circumstances of the Member. A decision to provide Benefits for alternate care or extended Covered Services in one case does not obligate the Plan to provide the same benefits again. Anthem is given the right, at any time, to alter or cease providing Benefits for alternate care or extended Covered Services. In such case, Anthem will notify the Member or the Member's representative in writing.

Anthem's decisions about, Prior Approval requests, Medical Necessity, Experimental or Investigational services and new technologies are not arbitrary. Anthem's Medical Director or Medical Services Division takes into consideration the recommendations of the Member's provider and clinical information when making a decision about a Member's Benefit eligibility. When appropriate to review a proposed service, Anthem's Medical Director or Medical Services Division considers published peer-review medical literature about the service, including the opinion of experts in the relevant specialty. At times, Anthem may consult with experts in the specialty. Anthem may also review determinations or recommendations of nationally recognized public and private organizations that review the medical effectiveness of health care services and technology.

Section 6: Emergency Care and Urgent Care

Please see Section 14 for definitions of specially capitalized words.

This Section is a guide to help you determine when you may need to go directly to a hospital for Emergency Care.

I. Urgent Care

Urgent care means Covered Services that you receive due to the onset of a condition that requires prompt medical attention but does not meet the definition of Emergency Care as defined in II (below). Examples of conditions that may require urgent care are: sprain, sore throat, rash, earache, minor wound, moderate fever, abdominal or muscle pain.

Whenever possible, contact an Anthem Participating Provider for direction when you need urgent medical care.

II. Emergency Care

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

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

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

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

III. Emergency Room Visits for Emergency Care

Benefits are available for Emergency Care and other emergency services in any licensed hospital emergency room.

IV. Inpatient Admissions to a Hospital for Emergency Care

Benefits are available for an Inpatient admission for Emergency Care as defined in II of this Section.

Section 7: Covered Services

Please see Section 14 for definitions of specially capitalized words.

This Section describes Covered Services for which Benefits are provided under the Plan. All Covered Services must be furnished by a Designated Provider. Preventive Care services are listed in article II, A of this Section. All other Covered Services must be Medically Necessary for the diagnosis and treatment of disease, illness, injury, or for maternity care. Otherwise, no Benefits are available.

Note: Benefits available under this plan are secondary to Medicare and do not duplicate coverage that is available under either Medicare Part A or Medicare Part B. With few exceptions, Benefits are available only after Medicare determines that your services are covered Medicare eligible expenses. If Medicare determines that your care is not covered, please contact Medicare for assistance first. Medicare's telephone number and address are shown on the "Explanation of Medicare Benefits" form issued to you by Medicare.

Please remember the Plan guidelines explained in Sections 1 through 4. Some important reminders are:

- Members are entitled to the Covered Services described in this Section. All Benefits are subject to the exclusions, conditions and limitations, terms and provisions described in Section 6 "Limitations and Exclusions" and elsewhere in this Benefit Booklet and any amendments to this Benefit Booklet.
- To receive maximum benefits for Covered Services, you must follow the terms of this Benefit Booklet, including using Anthem Participating Providers.
- Benefits for Covered Services are based on the Maximum Allowable Benefit for such service.
- Benefits for Covered Services will be limited by any annual, or lifetime payment limit in this Benefit Booklet.
- The fact that a provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment.
- Anthem makes determinations about Precertification, Medical Necessity, Experimental/ Investigational services and new technology based on the terms of this Benefit Booklet, including, but not limited to the definition of Medical Necessity found in Section 14 of this Benefit Booklet. Anthem's medical policy assists in Anthem's determinations. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Benefit Booklet take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. Please see Section 11 for complete information.

Please note: This Section often refers to your Cost Sharing Schedule. Important limitations are shown on your Cost Sharing Schedule.

I. Inpatient Services

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

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

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours.

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

C. Inpatient Physician and Professional Services. Physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests. Benefits for Inpatient medical care are limited to daily care furnished by the attending physician, unless another physician's services are Medically Necessary, as determined by your attending physician and Anthem. For Skilled Nursing and Physical Rehabilitation Facility admissions, *Benefits are limited to a certain number of Inpatient days per Member, per year, as shown on your Cost Sharing Schedule.*

Please see subsections V "Behavioral Health Care" and VI "Important Information About Other Covered Services" (below in this Section) for related information about Inpatient services. Also, see Section 8 for important limitations and exclusions that may apply to Inpatient Services.

II. Outpatient Services

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

A. Preventive Care

In general, the term "Preventive Care" under this Benefit Booklet refers to medical care for adults with no current symptoms or prior history of a medical condition associated with the care. For Members who have current symptoms or have been diagnosed with a medical condition, services associated with the symptoms or diagnoses are not Preventive Care. Some exceptions to this definition are listed below and may not be covered by Medicare. For those services, this Plan will be considered the primary payor and will follow the Plan's guidelines with respect to provider participation. For more information on participating and non-participating providers see Section 3 and 4 of this Benefit Booklet. Otherwise, services for the diagnosis or treatment of an illness, injury or medical condition are covered under other applicable sections of this Benefit Booklet. Whether or not a service is Preventive Care, Covered Services are subject to the cost sharing requirements specified on your Cost Sharing Schedule. For the purposes of this subsection, Preventive Care services are:

1. Immunizations for adults (including travel and rabies immunizations)
2. Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening
3. Routine physical exams for adults (including one annual gynecological exam)
4. Family planning visits, such as medical exams related to family planning and genetic counseling. Outpatient or office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Outpatient/office contraceptive services are: office visits, consultations, examinations and medical/surgical care related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, Norplant insertion or Depo-Provera injection. Please see Section 8, II, "Contraceptive Services" for limitations.

Please note: contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, Norplant and DepoProvera) are not covered under this Benefit Booklet. Please contact the State of New Hampshire's pharmacy benefits administrator for information about coverage for contraceptive drugs and devices.

Please see VI, C (below in this Section) for information about infertility services.

5. Nutrition counseling by a registered dietitian practicing independently or as part of a physician practice or Outpatient hospital clinic. Benefits are limited as shown on your Cost Sharing Schedule. This limit does not apply to visits for diabetes management or visits when diet is part of the medical management of a documented organic disease.

Note: other nutrition counseling Benefits are available when furnished by a Home Health Agency. Please see IV, B "Home Health Agency" below in this section for more information.

6. Diabetes management program. Covered Services include:

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

For information about diabetes education Programs or Anthem Participating Diabetes Education Providers, visit Anthem's website at www.anthem.com or call Anthem's Customer Service Center at the toll-free number listed on your identification card.

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

- No Benefits are available for services furnished by a provider who is not an Anthem Participating Diabetes Education Provider.
- Benefits are available for fees required to enroll in an approved group education program. However, no Benefits are available for costs related to materials, activities or supplies in addition to the enrollment fee.

Insulin, diabetic medications, blood glucose monitors, external insulin pumps and diabetic supplies are not covered under this subsection. Please see subsection IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" (below this subsection) for information about diabetic supplies. Please contact the State of New Hampshire's pharmacy benefit administrator for information about coverage for diabetic insulin, medications and supplies purchased at a pharmacy.

B. Medical/Surgical Care in a Physician's Office. In addition to Preventive Care commonly provided in a physician's office (see article A of this Section), the following services are covered:

1. Medical exams, consultations, office surgery and anesthesia, injections (including allergy injections), medical treatments (including allergy treatments)
2. Laboratory and x-ray tests (including allergy testing and ultrasound)

3. CT Scan, MRI, chemotherapy
4. Medical supplies and drugs administered in an office. Benefits are available for covered prescription medications, injectable drugs, radioactive materials, dressings and casts administered or applied in a provider's office for the prevention of disease, illness or injury or for therapeutic purposes.

Hormones, insulin and prescription drugs purchased at a physician's office for use outside the office are not covered under any portion of this Benefit Booklet. Durable medical equipment, medical supplies and prosthetics purchased for use outside a physician's office are not covered under this subsection. Please see subsection IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics," (below this Section) for coverage information. Please contact the State of New Hampshire's pharmacy benefit administrator for information about coverage for some of these items when purchased at a pharmacy.

5. Maternity care. Covered Services may be furnished by any licensed Obstetrician/Gynecologist, New Hampshire Certified Midwife (NHCM) or licensed Advanced Registered Nurse Practitioner (ARNP)

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

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

Covered Services rendered by a New Hampshire Certified Midwife (NHCM) are limited to *routine* total maternity care provided that the NHCM is certified under New Hampshire law and acting within a NHCM's scope of practice.

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

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

Also, see III, “Outpatient Physical Therapy Rehabilitation Services” (below)

D. Emergency Room Visits for Emergency Care. Covered services are shown on your Cost Sharing Schedule. Please see Section 6 for important information about Emergency Care and urgent care.

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

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

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

III. Outpatient Physical Rehabilitation Services

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

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

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

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

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

Physical, occupational and speech therapy services must be furnished during the acute care stage of an illness or injury. Therapy is covered for long-term conditions only when an acute medical condition occurs during the illness, such as following surgery. No Benefits are available for therapy furnished beyond the acute care stage of an illness or injury. Therapy services must be restorative, with the expectation of concise, measurable gains and goals as judged by your physician and by Anthem. Services must provide significant improvement within a reasonable and generally predictable period of time. Services must require the direct intervention, skilled knowledge and attendance of a licensed physical, occupational or speech therapist. Noncovered services include, but are not limited to: on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes including but not limited to lifestyle changes effecting the voice. Such on-going services are not covered, even if ordered by your physician or supervised by skilled program personnel. In addition to the limitations and exclusions listed in Section 8 of this Benefit Booklet, no Benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No Benefits are available for educational reasons or for Developmental Disabilities. No Benefits are available for sport, recreational or occupational reasons.

Benefits for Outpatient Physical Rehabilitation Services may be limited as shown on your Cost Sharing Schedule.

Please see Section 6, I, “Dental Services” for Benefit information about physical therapy or treatment of TMJ disorders.

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

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

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

Benefits for cardiac rehabilitation may be limited as shown on your Cost Sharing Schedule.

C. Chiropractic Care. The following are Covered Services when furnished by a chiropractor:

- **Office visits** for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment, and
- Medically Necessary diagnostic **laboratory and x-ray tests**

Benefits are limited as shown on your Cost Sharing Schedule.

In addition to the limitations and exclusions stated in Section 8, the following limitations apply specifically to chiropractic care:

Wellness care is not covered

- The services must be Medically Necessary for the treatment of an illness or injury that is diagnosed or suspected by a licensed chiropractor or another physician, and

- Chiropractic care must be furnished in accordance with New Hampshire law

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

D. Cognitive Rehabilitation. Cognitive rehabilitation visits are covered, provided that the therapy is Medically Necessary to treat a significant impairment to cognitive function after traumatic brain injury, such as skull fracture. Cognitive therapy must be furnished to improve attention, memory, problem solving and other cognitive skills through one-on-one contact between a Member and a licensed physical or occupational therapist. Except as described in this subsection, no Benefits are available for cognitive therapy. Cognitive therapy is not covered for the treatment of Alzheimer's disease, Parkinson's disease, autistic disorders, Asperberger's disorder and Developmental Disabilities or to treat the effects of stroke or cerebrovascular disease. *Benefits for cognitive rehabilitation visits may be limited as shown on your Cost Sharing Schedule.*

E. Pulmonary Rehabilitation. Pulmonary rehabilitation visits are covered for Members who are experiencing a restriction in ordinary activities and an impaired quality of life due to impaired pulmonary function. Benefits are limited to periodic evaluation and chest wall manipulation by a licensed physical therapist. *Benefits for pulmonary rehabilitation visits may be limited as shown on your Cost Sharing Schedule.*

IV. Home Care

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

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

B. Home Health Agency Services. Benefits are available for Medically Necessary services furnished by a Home Health Agency in your home or other place of residence. Benefits are available only when, due to the severity of a medical condition, it is not reasonably possible for you to travel from your home to another treatment site. Covered Services are limited to the following:

- Part-time or intermittent skilled nursing care by, or under the supervision of a Registered Nurse
- Part-time or intermittent home health aide services that consist primarily of caring for you under the supervision of a Registered Nurse
- Prenatal and postpartum homemaker visits. Homemaker visits must be Medically Necessary. Otherwise no Benefits are available. For example, if you are confined to bed rest or your activities of daily living are otherwise restricted by order of your physician, prenatal and/or postpartum homemaker visits may be considered Medically Necessary. When determining the Medical Necessity of such services, your physician will consult with Anthem's case manager.
- Physical, occupational, and speech therapy.

Nonprescription medical supplies. Nonprescription medical supplies may include surgical dressings and saline solutions. Prescription drugs, certain intravenous solutions and insulin are not included.

Please contact the State of New Hampshire's pharmacy benefit administrator for information about coverage for prescription drugs

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

- Care must be approved in advance by the Member's physician and by Anthem's Precertification,

- The patient must have a terminal illness with a life expectancy of six months or less, as certified by a physician,
- The patient, or his/her legal guardian, must make an informed decision to focus treatment on comfort measures when treatment to cure the condition is no longer possible or desired.
- The patient, or his/her legal guardian, the patient's physician and medical team must support hospice care because it is in the patient's best interest, and
- A primary care giver must be available on an around-the-clock basis. A primary care giver is a family member, friend or hired help who accepts 24-hour responsibility for the patient's care. The primary care giver does not need to live in the patient's home.

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

- Skilled nursing visits
- Home health aide and homemaker services
- Physical therapy for comfort measures
- Social service visits
- Durable medical equipment and medical supplies
- Respite care (in the home) to temporarily relieve the primary care giver from care-giving functions
- Continuous care, which is additional respite care to support the family during the patient's final days of life
- Bereavement services provided to the family or primary care giver following the death of the hospice patient

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

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

E. Durable Medical Equipment, Medical Supplies and Prosthetics. Benefits are available for covered durable medical equipment (DME), medical supplies and prosthetic devices. Covered Services must be ordered by a physician and furnished by a licensed medical equipment, medical supplies or prosthetics provider. Otherwise, no Benefits are available.

1. **Durable Medical Equipment (DME).** Benefits are available for covered DME. In order to be Covered, the DME must meet all of the following criteria. Otherwise, no Benefits are available.

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

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

Benefits are available for external insulin infusion pumps for insulin dependent diabetics. External insulin pumps must be approved in advance by Anthem. To determine eligibility, please ask your provider to contact Anthem for prior approval *before* you purchase the pump. Anthem will require treatment and clinical information in writing from your provider. Anthem will review the information and determine in writing whether the services are covered under this Benefit Booklet, based on the criteria stated in this Benefit Booklet and Anthem's guidelines for external infusion pumps. You may contact Anthem to request a copy of Anthem's internal guidelines or go to Anthem's website at www.anthem.com. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Benefit Booklet. Please see II, A, 5, "Diabetes Management Program" of this Section for information about external insulin pump education.

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

Therapeutic/corrective shoes, inserts or modifications to therapeutic/corrective shoes are considered medically necessary if the following criteria are met:

- a. The individual has diabetes mellitus; and
- b. The individual has one or more of the following conditions:
 - previous amputation of the other foot or part of either foot, or
 - history of previous foot ulceration of either foot, or
 - history of pre-ulcerative calluses of either foot, or
 - peripheral neuropathy with evidence of callus formation of either foot, or
 - foot deformity of either foot, or
 - poor circulation in either foot

The certifying physician who is managing the individual's systemic diabetes condition has certified that indications (a) and (b) above are met and that he/she is treating the individual under a comprehensive plan of care for his/her diabetes and that the individual needs therapeutic/corrective shoes, inserts or modifications to therapeutic/corrective shoes.

Benefits are available based on the criteria stated above. **Inserts for or modifications to non-therapeutic/non-corrective shoes are not covered.** For a copy of Anthem's internal guidelines, please contact Customer Service at the toll-free phone number on your identification card or visit Anthem's website at www.anthem.com.

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

Examples of covered medical supplies include: needles and syringes, ostomy bags and skin bond necessary for colostomy care. Eyewear (frames and/or lenses or contact lenses) is covered only if the lens of your eye has been surgically removed or is congenitally absent.

Other covered medical supplies are:

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

Note: Please contact the State of New Hampshire pharmacy benefit administrator for complete information about benefits that may be available for diabetic supplies purchased at a pharmacy.

- **Enteral formula and modified low protein food products.** Benefits are available for enteral **formulas** required for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length or motility of the gastrointestinal tract. Benefits are available for **food products modified to be low protein** for persons with inherited diseases of amino acids and organic acids. Your physician must issue a written order stating that the enteral formula and/or food product is:
 - needed to sustain life, and is
 - Medically Necessary;
 - The least restrictive and most cost-effective means for meeting your medical needs.

Otherwise, no Benefits are available. For covered modified low protein food products, Benefits are limited to a total of \$1,800 each Year.

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

Coverage for external breast prostheses is limited to the lowest cost alternative available that meets the Member's physical needs. The Maximum Allowable Benefit for breast prosthesis includes the cost of fitting for the prosthesis.

Clothing necessary to wear a covered prosthetic device is also covered. This includes stump socks worn with prosthetic limbs and post-mastectomy bras worn with breast prosthesis. Coverage for post-mastectomy bras is limited to the lowest cost alternative available that meets the Member's physical need.

A **scalp hair prosthesis** is an artificial substitute for scalp hair that is made specifically for you. Benefits are available for scalp hair prostheses as follows:

Scalp hair prostheses are covered for Members who have permanent hair loss as a result of alopecia areata, alopecia totalis, or as a result of accidental injury.

For Members who have hair loss as a result of alopecia medicamentosa resulting from the treatment of any form of cancer or leukemia, Benefits are limited to a total of \$350 per Member per year.

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

Except as described above, no Benefits are available for scalp hair prostheses or wigs. For example, except as stated above, no Benefits are available for temporary hair loss. No Benefits are available for male pattern baldness.

Limitations. In addition to the limitations and exclusions listed in Section 8, the following limitations apply specifically to this subsection:

- Whether an item is purchased or rented, Benefits are limited to the Maximum Allowable Benefit. Benefits will not exceed the Maximum Allowable Benefit for the least expensive service that meets your medical needs. If your service is more costly than is Medically Necessary, you will be responsible for paying the difference between the Maximum Allowable Benefit for the least expensive service and the charge for the more expensive service.
- If you rent or purchase equipment and Anthem pays Benefits equal to the Maximum Allowable Benefit, no further Benefits will be provided for rental or purchase of the equipment.
- Anthem determines if equipment should be rented instead of purchased. For example, if your physician prescribes a hospital bed for short-term home use, Anthem will require that the bed must be rented instead of purchased if short-term rental is less expensive than the purchase price. In such instances, Benefits are limited to what Anthem would pay for rental, even if you purchase the equipment. You will be responsible for paying the difference between the Maximum Allowable Benefit for rental and the charge for purchase.
- Burn garments (or burn anti-pressure garments) are covered only when prescribed by your physician for treatment of third degree burns, deep second degree burns or for areas of the skin which have received a skin graft. Covered burn garments include gloves, face hoods, chin straps, jackets, pants, leotards, hose or entire body suits which provide pressure to burned areas to help with healing.
- Support stockings are covered for a diagnosis of phlebitis or other circulatory disease. Gradient pressure aids (stockings) are covered only when prescribed by your physician and provided that the stockings meet Anthem's definition of Medical Necessity, as stated in Section 14 of this Benefit Booklet. Anti-embolism stockings are not covered. Inelastic compression devices are not covered. The Maximum Allowable Benefit for covered gradient pressure aids includes the Benefit for fitting of the garments. No additional Benefits are available for fitting.
- Neither rental nor purchase of manual breast pumps is covered.
- Electric breast pumps are not covered. Exception: Rental of an electric breast pump may be covered for up to two months, provided the pump is Medically Necessary, as defined in Section 14. Purchase of an electric breast pump is not covered.

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

Exclusions. In addition to the other limitations and exclusions stated in this Benefit Booklet, the following services are not covered. These exclusions apply, even if the services are provided, ordered or prescribed by a Designated Provider and even if the services meet Anthem’s definition of Medical Necessity found in Section 14 of this Benefit Booklet. No Benefits are available for:

- Arch supports, therapeutic/corrective shoes, foot orthotics (and fittings, castings or any services related to footwear or orthopedic devices) or any shoe modification. Please see “Durable Medical Equipment” (above) for exceptions to this exclusion.
- Special furniture, such as seat lift chairs, elevators (including stairway elevators or lifts), back chairs, special tables and posture chairs, adjustable chairs, bed boards, bed tables, and bed support devices of any type including adjustable beds,
- Glasses, sports bras, nursing bras and maternity girdles or any other special clothing, except as stated above in this subsection,
- Nonprescription supplies, first aid supplies, ace bandages, cervical pillows, alcohol, peroxide, betadine, iodine, or phisohex solution; alcohol wipes, betadine or iodine swabs, items for personal hygiene,
- Bath seats or benches (including transfer seats or benches), whirlpools or any other bath tub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans,
- Heat lamps, heating pads, hydrocoliator heating units, hot water bottles, batteries and cryo cuffs (water circulating delivery systems),
- Biomechanical limbs, computers, physical therapy equipment, physical or sports conditioning equipment, exercise equipment, or any other item used for leisure, sports, recreational or vocational purposes, any equipment or supplies intended for educational or vocational rehabilitation, motor vehicles or any similar mobility device that does not meet the definition of Durable Medical Equipment, as stated above in this subsection and/or does not meet Anthem’s definition of Medical Necessity as stated in Section 14 of this Booklet.
- Safety equipment, including, but not limited to: hats, belts, harnesses, glasses or restraints,
- Costs related to residential or vocational remodeling or indoor climate/air quality control, air conditioners, air purifiers, humidifiers, dehumidifiers, vaporizers and any other room heating or cooling device or system,
- Self-monitoring devices except as stated in 2 “Medical Supplies” (above), TENS units for incontinence, biofeedback devices, blood pressure cuffs, self-teaching aids, books, pamphlets, video tapes, video disks, fees for Internet sites or software, or any other media instruction or for any other educational or instructional material, technology or equipment; and
- Dentures, orthodontics, dental prosthesis and appliances. No Benefits are available for appliances used to treat temporomandibular joint (TMJ) disorders.
- Convenience Services are not covered. Convenience Services include, but are not limited to personal comfort items and any equipment, supply or device this is primarily for the convenience of a Member, the Member’s family or a Designated Provider.

V. Behavioral Health Care

Benefits are available for Medically Necessary Behavioral Health Care as stated below.

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

B. Covered Behavioral Health Care Services. Benefits are available for the diagnosis, crisis intervention and short-term treatment of acute Mental Disorders and Substance Abuse Conditions.

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

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

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

Outpatient/office Visits. Covered Services are: evaluation, therapy, and counseling for Mental Disorders and Substance Abuse Conditions. Group Therapy visits are covered. *Benefits for Outpatient/office visits are shown on your Cost Sharing Schedule.* Visits for psychological testing and medication checks are covered. Emergency room visits are not covered under this subsection. Emergency visits are covered under the terms of Section 6, “Emergency Care and Urgent Care.”

Covered Services must be furnished by Eligible Behavioral Health Providers. Eligible Behavioral Health Providers of Outpatient/office visits are: Clinical Social Workers, Clinical Mental Health Counselors, Community Mental Health Centers, Licensed Alcohol and Drug Abuse Counselors, Marriage and Family Therapists, Pastoral Counselors, Psychiatrists, Psychiatric Advanced Registered Nurse Practitioners, and Psychologists.

Intensive Outpatient Treatment Programs - Benefits are available for Intensive Outpatient Treatment Programs (sometimes called “day/evening” programs) for treatment of Mental Disorders and for Substance Abuse Conditions. Covered Services include facility fees, counseling and therapy services typically provided by an Intensive Outpatient Treatment Program. Benefits for Intensive Outpatient Treatment Program visits are limited, as shown on your Cost Sharing Schedule.

Covered Services must be furnished by an Intensive Outpatient Treatment Program as defined in C, “Eligible Behavioral Health Providers,” below in this subsection.

Inpatient Care. Benefits are available for Inpatient care as follows:

- For **Mental Disorders**, Covered Services include Medically Necessary semi-private room and board, nursing care and other facility fees, Inpatient counseling and therapy services typically provided as part of an Inpatient admission for treatment of Mental Disorders.

Covered Services must be furnished by an Eligible Behavioral Health Provider. Eligible Behavioral Health

Providers of Inpatient facility care are: Private Psychiatric Hospitals, Public Mental Health Hospitals, Residential Psychiatric Treatment Facilities and Short Term General Hospitals. Please see C, “Eligible Behavioral Health Providers” (below) for definitions of these providers.

- For **Substance Abuse Conditions**, Covered Services include Medically Necessary semi-private room and board, nursing care and other facility fees, Inpatient counseling and therapy services typically provided as part of an Inpatient admission for treatment of Substance Abuse Conditions during the acute detoxification stage of treatment or during stages of rehabilitation. Inpatient Benefits are limited, as shown on your Cost Sharing Schedule.

Covered Services must be furnished by an Eligible Behavioral Health Provider. Eligible Behavioral Health Providers of Inpatient facility care for substance abuse detoxification are: Short Term General Hospitals and Private Psychiatric Hospitals. Eligible Behavioral Health Providers of Inpatient facility care for rehabilitation are: Private Psychiatric Hospitals and Substance Abuse Treatment Providers. Please see C, “Eligible Behavioral Health Providers” (below) for definitions of these providers.

Please note: If you are admitted by a medical/surgical physician (not a Behavioral Health Provider) to a Short Term General Hospital for medical detoxification, Benefits are available according to the terms of I, “Inpatient Services,” above in this Section and to the terms of Section 6, “Emergency Care and Urgent Care.”

Partial Hospitalization Programs - Benefits are available for Partial Hospitalization Programs (sometimes called “day/evening” programs) for treatment of Mental Disorders and for Substance Abuse Conditions. Covered Services include facility fees, counseling and therapy services typically provided by a Partial Hospitalization Program.

Covered Services must be furnished by a Partial Hospitalization Program. Please see C, “Eligible Behavioral Health Providers” (below) for definitions of a Partial Hospitalization Program.

Scheduled Ambulance Transport - Benefits are available for Medically Necessary ambulance transport from one facility to another. If transport in a non-emergency vehicle (such as by car) is medically appropriate, ambulance transport is not covered. No Benefits are available for the cost of transport in vehicles such as chair ambulance, car or taxi.

Note: *Emergency* ambulance transportation is not covered under this subsection. Please see II, E, “Ambulance Services” (above in this Section) for complete information.

C. Eligible Behavioral Health Providers. Behavioral Health Care must be furnished by a Behavioral Health Provider. Otherwise, no Benefits are available. Eligible Behavioral Health Provider are limited to the following:

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

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

Community Mental Health Center. A licensed center approved by the Director of the Division of Mental Health and Developmental Services, Department of Health and Human Services of the State of New Hampshire as a Community Mental Health Center as defined in the Community Mental Health Centers Act of 1963 or licensed in accordance with the provisions of the laws of the state in which they practice which meet or exceed the certification standards of the State of New Hampshire.

Intensive Outpatient Treatment Program. An intensive, nonresidential behavioral health program designed to reduce or eliminate the need for an Inpatient admission. The program must provide multidisciplinary structured therapeutic group treatment under the direction of a qualified provider. A qualified provider is an Eligible Mental Health and/or Substance Abuse Provider who has achieved at least a master's degree in his or her field of practice and is practicing within the scope of his or her license. In most instances, the program will operate at least three hours per day, three days per week.

Licensed Alcohol and Drug Abuse Counselor. An individual who is licensed as an Alcohol and Drug Abuse Counselor under New Hampshire law. An Alcohol and Drug Abuse Counselor may also be an individual whose practice is conducted outside New Hampshire must be licensed or certified to practice independently as an Alcohol and Drug Abuse Counselor according to the law in the state where the individual's practice is conducted. Otherwise, the individual is not an Eligible Behavioral Health Provider.

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

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

Pastoral Counselor. A professional who is licensed under New Hampshire law and who is a fellow or diplomate in the American Association of Pastoral Counselors.

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

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

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

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

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

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

Substance Abuse Treatment Provider. A facility that is approved by Anthem which meets the following criteria: is licensed, certified or approved by the state where located to provide substance abuse rehabilitation, and is affiliated with a hospital under a contractual agreement with an established patient referral system, or is accredited by the Joint Commission on Accreditation of Hospitals as a Substance Abuse Treatment Provider.

Note: Benefits are provided for Covered Services furnished by Eligible Behavioral Health Providers located outside New Hampshire only when the provider is licensed according to state requirements that are substantially similar to those required by Anthem. Also, the provider must meet the educational and clinical standards that Anthem requires for health care provider eligibility. Otherwise, no Benefits are available.

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

- Benefits are available only for Mental Disorders and Substance Abuse Conditions that are subject to favorable modification through short-term therapy. The Mental Disorder or Substance Abuse Condition must be shown to affect the ability of a Member to perform daily activities at work, at home, or at school.
- Benefits are available for approved periodic care for a chronic Mental Disorder to prevent deterioration of function. Additionally, Benefits will be provided for approved expenses arising from the diagnosis and evaluation of all other mental illnesses and emotional disorders.
- Services must be problem-focused and goal-oriented and demonstrate ongoing improvement in a Member's condition or level of functioning.
- Services must be in keeping with national standards of Behavioral Health professional practice as reflected by scientific and peer specialty literature.
- Services must be provided at the level of care appropriate to the severity of the Member's illness or condition and capacity to respond to professionally provided treatment.
- Services must be within the professional competence and licensed scope of practice of the Eligible Designated Mental Health or Substance Abuse Provider furnishing the care.

E. Exclusions. In addition to the limitations and exclusions listed in Section 8, no Benefits are available for the following:

- Services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder or Substance Abuse Condition which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to, mental retardation, Developmental Disabilities, behavioral disabilities and characterological disorders.
- Duplication of services (the same services provided by more than one therapist during the same period of time),
- Treatment of obesity or weight control programs or services,
- Custodial care, Convenience Services, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling,

- Services for nicotine withdrawal or nicotine dependence,
- Psychoanalysis,
- Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings,
- Missed appointments,
- Telephone therapy or any other therapy or consultation that is not “face-to-face” interaction between the patient and the provider,
- Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition,
- Care extending beyond short-term therapy for detoxification and/or rehabilitation for a Substance Abuse Condition in an Outpatient/office setting,
- Experimental/Investigational services or nontraditional therapies such as, but not limited to crystal or aroma therapies
- With the exception of Emergency Care, no Benefits are available for services that you receive on the same day that you participate in a partial hospitalization program or Intensive Treatment Program.
- No Benefits are available for care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services.

VI. Important Information About Other Covered Services

This subsection includes examples of services that are covered and often require use of other Covered Services defined above in subsections I-V. The limitations and exclusions stated in this subsection are in addition to those stated in Section 8. Limitations and exclusions apply even if you receive services from your physician or according to your physician’s order or according to the recommendation of another Designated Provider and even if the service meets Anthem’s definition of Medical Necessity. No Benefits are available for any services performed in conjunction with, arising from, or as a result of complications of a non-covered service.

All of the plan rules, terms and conditions stated elsewhere in this Benefit Booklet apply to the services in this subsection. For example, Inpatient and Outpatient care described in this subsection is subject to the terms of I, “Inpatient Services” and II, “Outpatient Services” (above in the Section).

A. Dental Services

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

Under this Benefit Booklet, Benefits are limited to the following Covered Dental Services. No other Dental Service is a Covered Service.

1. **Accidental injury.** Benefits are available for Dental Services to treat an accidental injury to sound natural teeth, provided that the dental treatment is a continuous course of treatment that begins within six months of the date of injury. Otherwise, no Benefits are available for Dental Services related to an accidental injury or arising from the injury or a complication of the injury. Exceptions are stated in 2, 3, and 4 (below). No Benefits are available for treatment to repair, restore or replace dental services such as fillings, crowns, caps or appliances that are damaged as a result of an accident. No Benefits are available for treatment if you damage your teeth or appliances as a result of biting or chewing.

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

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

- a. Surgical removal (extraction) of erupted teeth before radiation therapy for malignant disease. Benefits are limited to:

- The surgeon's fee for the surgical procedure,
- General anesthesia furnished by a licensed anesthesiologist or anesthesiologist who is not the surgeon.

- b. Surgical removal of bone impacted teeth and gingivectomy. Benefits are limited to:

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

Regarding 2, a and b (above): No Benefits are available for related preoperative or postoperative care, including medical, laboratory and x-ray services. No benefits are available for local anesthesia services by the surgeon, surgical exposure of impacted teeth to aid eruption, osseous and flap procedures in conjunction with gingivectomy or any other services for periodontal disease (such as scaling and root planing, prophylaxis and periodontal evaluations). No Benefits are available for facility fees, except as stated in 5 below in this Section.

- c. Surgical correction of a facial bone fracture (not to include the portion of upper and lower jaws that contain the teeth, except as otherwise stated in this subsection) and surgical removal of a lesion or tumor by a dentist or oral surgeon are covered to the same extent as any other surgical procedure covered under this Benefit Booklet.

Cost sharing amounts for covered oral surgery, anesthesia, office and facility care are shown in parts I and II of your Cost Sharing Schedule.

3. **Non-surgical Treatment of Temporomandibular Joint (TMJ) disorders.** Benefits are limited to:

- a. Medical exams and medical treatment, as follows:

- The initial evaluation,
- Follow-up treatment for adjustment of an orthopedic repositioning splint, and
- Trigger point injection treatment.

- b. Diagnostic x-rays of the TMJ joint and other facial bones.
- c. Physical therapy. Physical therapy services to treat TMJ disorder must be furnished by a licensed physical therapist. The services must be billed separately from the services of the dentist or oral surgeon who provide other covered surgical and nonsurgical portions of your TMJ treatment. Otherwise, no Benefits are available for physical therapy services for TMJ disorders.

No Benefits are available under any portion of the Benefit Booklet for TMJ appliances, splints, orthopedic devices, orthodontia or orthodontics for treatment of TMJ disorders. No Benefits are available for diagnostic arthroscopy.

The Covered Services described above are subject to the cost sharing amounts shown on your Cost Sharing Schedule for medical exams, medical treatments, x-rays and physical therapy.

- 4. **Surgical correction or repair of the temporomandibular joint (TMJ)** is covered, provided that the Member has completed at least five months of medically documented unsuccessful non-surgical treatment. Coverage is limited to surgical evaluation and surgical procedures that are Medically Necessary to correct or repair a disorder of the temporomandibular joint, caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations. Otherwise, no Benefits are available. Administration of general anesthesia by a licensed anesthesiologist or anesthesiologist is covered in conjunction with a covered surgery. Medically Necessary Inpatient and Outpatient hospital care is covered in conjunction with a covered surgery, subject to all of the terms of this Benefit Booklet.

Cost sharing amounts for surgery, anesthesia and facility care are shown under parts I and II of your Cost Sharing Schedule.

- 5. Benefits are available for hospital facility charges (Inpatient or Outpatient), surgical day care facility charges and general anesthesia furnished by a licensed anesthesiologist or anesthesiologist when it is Medically Necessary for certain Members to undergo a dental procedure under general anesthesia in a hospital facility or surgical day care facility. Members who are eligible for facility and general anesthesia Benefits are:

Members who have exceptional medical circumstances or a Developmental Disability. The exceptional medical circumstance or the Developmental Disability must be one that places the Member at serious risk unless the dental procedure is done under general anesthesia and must be done in a hospital or surgical day care facility setting. Patient anxiety is not an exceptional medical circumstance or Developmental Disability establishing eligibility for coverage under this subsection. The Member's physician and Anthem must approve the services *in advance*.

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

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

- a. Except as specifically stated in 1 to 5 above, no Benefits are available for facility fees, professional fees, anesthesia related to Dental Services or any other care relating to the teeth and supporting structures, such as the gums, tooth sockets in the jaw and the soft or bony portions of upper and lower jaws that contain the teeth. Except as specifically stated in 3 and 4 above, no Benefits are available for any service relating to care of the temporomandibular joint (TMJ). No Benefits are available for any condition that is related to, arising from or is a complication of a noncovered service.
- b. The Maximum Allowable Benefit for surgery includes the Benefit payment for IV sedation and/or local anesthesia. For any surgical Dental Service covered under this subsection, no Benefits beyond the surgical Maximum Allowable Benefit are available for IV sedation and/or local anesthesia.
- c. Except as stated in 1 to 5 above, no Benefits are available for treatment or evaluation of a periodontal disorder, disease or abscess. Osseous and flap procedures furnished in conjunction with gingivectomy or any service related to periodontal disease (such as scaling and root planing, prophylaxis and periodontal evaluations) are not covered.
- d. No Benefits are available for preventive Dental Services.
- e. Except as stated in 1 to 5 above in this subsection, no Benefits are available for restorative Dental Services, even if the underlying dental condition affects other health factors.
- f. No Benefits are available for noncovered dental procedures, even when your physician and Anthem authorize hospitalization and general anesthesia covered under this subsection.
- g. X-rays of the teeth are covered only when the terms of 1 (above) are met. Otherwise, x-rays of the teeth are not covered under any portion of this Benefit Booklet. Orthopantagrams are not covered.
- h. Orthodontia, TMJ appliances, splints or guards, braces, false teeth and biofeedback training are not covered under any portion of this Benefit Booklet.

B. Hearing Services

No Benefits are available for routine hearing services to determine the need for hearing correction. Benefits are available under this subsection for diagnosis and treatment of ear disease or injury. Covered Services (Inpatient and Outpatient care) are described throughout this subsection. Cost sharing amounts are shown under parts I and II of your Cost Sharing Schedule. Your physician must find or suspect injury to the ear or a diseased condition of the ear. Otherwise, no Benefits are available. For example, Benefits are available for laboratory hearing tests furnished by an audiologist, provided that you are referred to the audiologist by your physician who finds or suspects injury to the ear or a diseased condition of the ear. No Benefits are available for hearing aids except as stated in IV, E “Durable Medical Equipment, Medical Supplies and Prosthetics.”

C. Infertility Diagnostic Services

Benefits are limited to the Infertility Diagnostic Services listed in this subsection. For the purposes of determining Benefit availability, “Infertility” is defined as the diminished or absent capacity to create a pregnancy. Infertility may occur in either a female or a male.

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

Covered Services. After the applicable time limit is met, Benefits are available for the following Covered Services:

- Medical exams,
- Laboratory tests, including sperm counts and motility studies, sperm antibody tests, cervical mucus penetration tests,
- Surgical procedures, and
- Ultrasound and other imaging exams, such as hysterosalpingography, to determine the cause of infertility or to establish tubal patency

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

Except as stated above, no Benefits are available for any services to diagnose or treat infertility or for any care (Inpatient or Outpatient) that is related to, arising from or is a complication of a noncovered service.

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

- Surgical procedures to correct medical conditions contributing to infertility,
- Any infertility procedure performed during an operation not related to an infertility diagnosis,
- Male or female fertility drugs and hormones, and any service to prescribe or monitor the use of fertility drugs or hormones,
- Sonograms (ultrasounds), laboratory services, radiological services or any other service related to a noncovered procedure,
- Egg or sperm procurement, harvesting or processing (including donor services), egg or sperm banking, storage or cryopreservation, microfertilization (egg drilling or tweaking),
- Sperm penetration assays, electroejaculation procedures,
- Intracervical or intrauterine (IUI) artificial insemination (AI), using the partner's sperm (AIH) or donor sperm (AID),
- Assisted reproduction technology (ART), such as intravaginal culture, microvolume straw technique, in-vitro fertilization and embryo transfer (IVF-ET), natural oocyte retrieval (NORIF or NORIVF), gamete intrafallopian transfer (GIFT), peritoneal ovum and sperm transfer (POST), zygote intrafallopian transfer (ZIFT), cryopreservation of embryos or cryopreserved embryo transfer (CET), direct intraperitoneal insemination (DIPI), intracytoplasmic sperm injection (ICSI), preimplantation genetic diagnosis (PGD),
- Culture and fertilization of oocytes, co-culture of embryos and assisted embryo hatching,

- Microsurgical epididymal sperm aspiration (MESA),
- Genetic engineering, any selective fetal reduction,
- Any service related to achieving pregnancy through surrogacy or gestational carriers,
- Diagnosis and treatment following voluntary sterilization,
- Reversal of voluntary sterilization, and treatment needed as a result of successful or unsuccessful sterilization reversal,
- Supplies (such as thermometers and kits to predict ovulation),

Menopause in a woman is considered a natural condition and is not considered to be infertility, as defined in this subsection. No Benefits are available for infertility diagnosis, procedures or treatment for a woman who is menopausal or perimenopausal (or for their male partners), unless the woman is experiencing menopause at a premature age.

The above exclusions apply whether or not a Member has a medically documented diagnosis of infertility.

If you have questions about Benefit eligibility for a proposed Infertility Service, you are encouraged to ask your physician to contact Anthem *before* you receive the service. Your physician should submit a written description of the proposed service to: Anthem Blue Cross and Blue Shield, P.O. Box 660 North Haven, CT 06473-0660.

Anthem will review the information and determine in writing whether the requested service is covered or excluded under this Benefit Booklet. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Benefit Booklet.

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

D. Organ and Tissue Transplants

Organ and tissue transplants are covered according to the terms of this subsection. Covered Services (Inpatient and Outpatient) are stated in Section 7. Transplants must be ordered by your physician and approved in advance by Anthem. You and the organ donor must receive services from an Anthem Participating Provider, Contracting Provider or other Designated Provider, as determined by Anthem. Otherwise, you will be responsible for balances over the Maximum Allowable Benefit and the provider's charge.

The organ recipient must be a Member. You must meet all of the criteria for transplant eligibility as determined by Anthem and by the provider. The transplant must be generally considered the treatment of choice by Anthem and by the provider. Transplants are not covered for patients with certain systemic diseases, contraindications to immunosuppressive drugs, positive test results for HIV (with or without AIDS), active infection, active drug, alcohol or tobacco use or behavioral or psychiatric disorders likely to compromise adherence to strict medical regimens and post-transplant follow-up.

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

- Cornea, heart, heart-lung, kidney, kidney-pancreas, liver, and pancreas

- Allogeneic (HLA identical match) bone marrow transplants for acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma (for children who are at least one year old), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, Thalassemia major and Wiskott-Aldrich syndrome;
- Autologous bone marrow (autologous stem cell support) transplants and autologous peripheral stem cell support transplants for acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Autologous bone marrow transplants are covered for breast cancer consistent with New Hampshire insurance law regarding autologous bone marrow transplants.
- Single or double lung transplants for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension and emphysema. Double lung transplants are covered for cystic fibrosis.
- Small bowel transplants for Members with short bowel syndrome when there is irreversible intestinal failure, an established TPN (total parenteral nutrition) dependence for a minimum of two years, or there is evidence of severe complications from TPN. Simultaneous small bowel/liver transplants are covered for children and adults with short bowel syndrome when there is irreversible intestinal failure, an established TPN dependence for a minimum of two years, evidence of severe complications from TPN or evidence of impending end-stage liver failure.
- Travel expenses. Benefits are available for a transplant recipient's transportation, lodging and food expenses, provided that the transplant is furnished by an Anthem Participating Provider. **Benefits are limited to \$10,000 per covered transplant per lifetime.** No Benefits are available for services furnished by a Nonparticipating Provider.

No travel expense Benefit is available to an organ donor, even if the donor is a Member under this Benefit Booklet. Subject to all the terms of this subsection, the travel expense Benefit is available for the recipient's:

- Evaluation and candidacy assessments,
- Transplant event, and
- Post-transplant care.

The travel expense Benefit may also be used to obtain reimbursement for transportation, lodging and food costs incurred by one companion who accompanies the recipient during any of the above-listed events. The companion may be any person actively involved as the recipient's caregiver including, but not limited to the recipient's spouse, a member of the recipient's family or the recipient's legal guardian.

The travel expense Benefit is not available for the following:

- Cornea transplants,
- Cost incurred due to travel within 60 miles of the recipient's home,
- Laundry bills, telephone bills,
- Alcohol or tobacco products,
- Charges for transportation that exceed coach class rates,

- Expenses that exceed the \$10,000 per transplant, per lifetime travel expense Benefit.

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

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

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

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

E. Qualified Clinical Trials: Routine Patient Care

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

1. The drug or device under study must be approved for sale by the FDA (regardless of indication).
2. The drug or device under study must be for cancer or any other life-threatening condition.
3. The drug or device must be the subject of a qualified clinical trial approved by one of the following:
 - A National Institute of Health (NIH),
 - An NIH cooperative group or an NIH center,
 - The FDA (in the form of an Investigational new drug application or exemption)
 - The federal department of Veterans Affairs or Defense, or
 - An institutional review board of an institution in New Hampshire that has a multiple assurance contract approved by the Office of Protection from Research Risks of the NIH.
4. Standard treatment has been or would be ineffective, does not exist or there is no superior non-Investigational treatment alternative.
5. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise.
6. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least

as effective as the non-Investigational alternative.

7. For phase III or IV qualified clinical trials (qualified clinical trials involving leading therapeutic or diagnostic alternatives) Benefits are available for routine patient care, provided that all of the conditions stated in this subsection are met, and subject to all of the other terms and conditions of this Benefit Booklet.
8. For phase I or II qualified clinical trials (qualified clinical trials involving emerging technologies), Benefits are available for routine patient care only if:
 - All of the conditions stated in this subsection are met and subject to all of the other terms and conditions of this Benefit Booklet, and
 - Anthem reviews all of the information available regarding your individual participation in a Phase I or II qualified clinical trial and determines that Benefits will be provided for your routine patient care. Otherwise, no Benefits are available for routine patient care related to phase I or II qualified clinical trials.

Routine patient care means the Medically Necessary Covered Services described in this Benefit Booklet for which Benefits are regularly available, no applicable exclusion is stated in this Benefit Booklet and for which reimbursement is regularly made to an Anthem Participating Provider according to the terms of the provider's agreement with Anthem. For example, if surgery is Medically Necessary to implant a device that is being tested in a phase III or IV qualified clinical trial, the surgery and any Medically Necessary hospital care are covered according to the terms and conditions of this Benefit Booklet. Plan rules and cost sharing rules apply to routine patient care as for any other similar service. For Phase I and II qualified clinical trials, Anthem determines Benefit eligibility for routine patient care on a case-by-case basis.

Routine patient care does not include:

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

F. Required Exams or Services

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

Court ordered examinations or services are covered, provided that:

- The services are Medically Necessary Covered Services furnished by an Eligible Behavioral Health Provider or another Designated Provider, and
- All of the terms and conditions of this Benefit Booklet are met.

G. Surgery

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

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

- The surgery is a Covered Service, and
- The surgery is not on Anthem's list of surgical procedures that do not require a Surgical Assistant. Anthem's list is changeable. Please contact your surgeon or Customer Service before your surgery to obtain the most current information. Anthem's toll-free number is on your identification card.

Administration of general anesthesia is covered, provided that:

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

Surgery includes correction of fractures and dislocations, delivery of a baby, endoscopies and any incision or puncture of the skin or tissue that requires the use of surgical instruments to provide a Covered Service. Surgery does not include any service excluded from coverage under the terms of this Benefit Booklet.

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

1. **Reconstructive surgery.** Benefits are available for Medically Necessary reconstructive surgery only if at least one of the following criteria is met. **Reconstructive surgery or services must be:**
 - Made necessary by accidental injury; or
 - Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
 - Medically Necessary to restore or improve a bodily function, or

- Necessary to correct birth defects for covered dependant children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this Benefit Booklet.
- Benefits are available for breast reconstruction following mastectomy for patients who elect reconstruction. Breast reconstruction can include reconstruction to both effected breasts or one effected breast. Reconstruction can also include reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast (to produce a symmetrical appearance) in the manner chosen by the patient and the physician.

Reconstructive surgery or procedures or services that do not meet at least one of the above criteria is not covered under any portion of this Benefit Booklet. Provided that the above definition of reconstructive surgery is met, the following reconstructive surgeries are eligible for Benefits:

- Mastectomy for Gynecomastia,
- Port wine stain removal.

Benefits are available based on the criteria stated in this Benefit Booklet. For a copy of Anthem's internal guidelines, please contact Customer Service at the toll-free phone number on your identification card. Please see IV, E (above in this Section), "Durable Medical Equipment, Medical Supplies and Prosthetics," for information about Benefits for helmets or adjustable bands used to change the shape of an infant's head.

2. **Cosmetic Services.** Cosmetic Services are not covered under any portion of this Benefit Booklet. Please see Section 8, II for a definition of "Cosmetic Services."
3. **Dental Services.** Dental Services, including surgical treatment of TMJ disorders, are covered only as stated in VI, A, "Dental Services" (above). Except as stated in VI, A (above), no Benefits are available under any portion of this Benefit Booklet for Dental Services, including dental surgery.
4. **Postoperative medical care.** The Maximum Allowable Benefit for surgery includes the Benefit payment for postoperative medical care. No Benefits beyond the surgical Maximum Allowable Benefit are available for surgery-related postoperative medical care. Please see Section 14 for a definition of the Maximum Allowable Benefit.
5. **Surgery for weight loss or weight management.** Benefits are available for Medically Necessary gastric restrictive surgery. **If you are considering gastric restrictive surgery, you should ask your physician to contact Anthem for prior approval *before* the surgery is provided. Whether Anthem reviews weight loss surgery before or after the surgery is performed, Anthem will require treatment and clinical information in writing from your physician.** Anthem will review the information and determine in writing whether the services are covered or excluded under this Benefit Booklet. You may contact Anthem to request a copy of Anthem's internal guidelines or go to Anthem's website at www.anthem.com. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Benefit Booklet.

Minimum eligibility criteria are:

- A Member must have clinically severe obesity.
- The member must have actively participated in non-surgical methods of weight reduction, such as dietary and lifestyle changes, including regular exercise, and the non-surgical methods must have failed. The Member's participation in and the failure of non-surgical methods must be documented in medical records. Non-surgical methods of weight reduction are not covered.

Revision of a gastric restrictive procedure is covered only if all of the above criteria are met *and* the revision is

Medically Necessary due to a complication of the initial covered surgery or a covered revision. Examples of qualifying complications are: fistulas, and obstructions or disruptions of suture/staple lines.

No Benefits are available for malabsorptive procedures, such as biliopancreatic bypasses. Exception: Based on Anthem's internal guidelines and clinical information from your physician, Anthem may determine that Benefits are available for a biliopancreatic bypass with duodenal switch for an adult Member. Otherwise, no Benefits are available for any malabsorptive procedure or biliopancreatic bypass.

No Benefits are available for stretching of a stomach pouch formed by a previous gastric restrictive surgery due to the patient overeating.

No Benefits are available for gastric bypass with anastomosis ("mini" gastric bypass).

Except as stated in Section 7, II, A, "Preventative Care" (nutritional counseling and diabetes management), non-surgical methods of weight management are not covered. Except as stated above in this subsection, no Benefits are available for surgery for obesity, weight loss or weight control. This exclusion applies, even if the surgery is ordered by your physician or performed or ordered by another Designated Provider. The exclusion applies even if the surgery meets Anthem's definition of Medical Necessity and/or health complications arising from the obesity are documented.

6. **Organ/tissue transplant surgery.** Please see D, "Organ and Tissue Transplants" (above in this Section) for important information about coverage and limitations for organ/tissue transplant surgery.
7. **Intravenous (IV) Sedation and local anesthesia.** The Maximum Allowable Benefit surgery includes the Benefit payment for IV sedation and/or local anesthesia. No Benefits beyond the surgical Maximum Allowable Benefit are available for IV sedation and/or local anesthesia.
8. **Surgery related to noncovered services.** No Benefits are available for surgery or any other care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services. This exclusion applies even if the service is furnished or ordered by your physician or other Designated Provider and meets Anthem's definition of Medical Necessity.

If your proposed surgical services may be considered noncovered reconstructive, cosmetic, dental, weight loss/weight management surgery or if your surgical services may be considered noncovered under other portions of this Benefit Booklet, you should contact Anthem before you receive the services. Please ask your physician to submit a written description of the service to: Anthem Blue Cross and Blue Shield, P.O. Box 660 North Haven, CT 06473-0660. Anthem will review the information and determine in writing whether the requested services are covered or excluded under this Benefit Booklet. Anthem's review determination is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Benefit Booklet.

H. Vision Services

Benefits are available for Covered Services for the *diagnosis and treatment of eye disease or injury*. Covered Services (Inpatient and Outpatient care) are described throughout this Section. No Benefits are available for routine vision care to determine the need for vision correction or for the prescription and fitting of corrective lenses, including contact lenses. No Benefits are available for services, supplies or charges for eye surgery to correct errors of refraction, such as near-sightedness, including, without limitation, radial keratotomy and PRK Laser (photo refractive keratectomy) or excimer laser refractive keratectomy. Eyewear (frames, lenses and contact lenses) is covered for medical conditions only as stated in subsection IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics."

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

Section 8: Limitations and Exclusions

Please see Section 14 for definitions of specially capitalized words.

I. Limitations

The following are important limitations that apply to the Covered Services listed in Section 7. In addition to other limitations, conditions or exclusions set forth elsewhere in this Benefit Booklet, Benefits for expenses related to the services, supplies, conditions or situations described in this subsection are limited as indicated below. Limitations apply to these items and services even if you receive them from your physician or according to your physician's order or according to the recommendation of another Designated Provider. All of the plan rules, terms and conditions stated elsewhere in this Benefit Booklet apply to services described in this subsection.

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

Anthem makes determinations about Precertification, Medical Necessity, Experimental / Investigational services and new technology based on the terms of this Benefit Booklet, including, but not limited to the definition of Medical Necessity found in Section 14. Anthem's medical policy assists in Anthem's determinations. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Benefit Booklet take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. Please see Section 11 for complete information.

A. Private Room. If you occupy a private room, you will have to pay the difference between the hospital's charges for private room and the hospital's most common charge for a semi-private room, unless it is Medically Necessary for you to occupy a private room. Your physician must provide Anthem with a written statement in advance regarding the Medical Necessity of your use of a private room. Anthem will review the statement and make a determination about the availability of Benefits for use of a private room.

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

- Ultraviolet light therapy is covered for treatment of atopic dermatitis, chronic urticaria, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), pityriasis lichenoides, pityriasis rosea, pruritus of renal failure, psoriasis or vitiligo.
- Psoralen with Ultraviolet A light therapy is covered for treatment of acute or chronic pityriasis lichenoides, atopic dermatitis, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), psoriasis and vitiligo.
- Ultraviolet laser therapy for the treatment of inflammatory skin disorders such as psoriasis, provided that:
 1. The inflammation is limited to less than or equal to 10% of the member's body surface area, and
 2. The Member has undergone conservative therapy with topical agents, with or without standard non-laser ultraviolet light therapy and the conservative therapy was not successful as documented in medical records.

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

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

II. Exclusions

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

Anthem makes determinations about Precertification, Medical Necessity, Experimental/ Investigational services and new technology based on the terms of this Benefit Booklet, including, but not limited to the definition of Medical Necessity found in Section 14. Anthem’s medical policy assists in Anthem’s determinations. Anthem’s medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this Benefit Booklet take precedence over medical policy. You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Medical Necessity. The appeal procedure is stated in Section 11 in this Benefit Booklet.

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

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

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

Artificial Insemination. In general terms, “artificial insemination” refers to insemination by any means other than natural sexual intercourse. Except as stated in Section 7, VI, “Infertility Diagnostic Services,” no Benefits are available for artificial insemination.

Biofeedback Services. Biofeedback services are not covered.

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

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

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

If an Inpatient admission begins before the effective date of this Benefit Booklet, Benefits will be provided under this Benefit Booklet for Inpatient days occurring on or after the effective date of this Benefit Booklet. Benefits are subject to all of the terms and conditions of this Benefit Booklet for Medically Necessary Inpatient services.

Exception: If the terms of a prior carrier's benefit booklet or policy provide coverage for the entire admission (admission date to discharge date), no Benefits are available under this Benefit Booklet for any portion of the admission.

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

Care or Complications Related To Noncovered Services. No Benefits are available for the cost of any noncovered service or for the cost of any care related to, arising from, the result of, caused by or provided in connection with a noncovered service or for complications arising from a noncovered service. This exclusion applies even if a noncovered service or a related service is furnished or ordered by your physician or other Designated Provider and/or the service meets Anthem's definition of Medical Necessity. *Exception:* In Section 7, VI, A "Dental Services," Benefits are provided for facility and anesthesia services related to noncovered dental care, as required under New Hampshire law.

No Benefits are available for expenses incurred when you choose to remain in a hospital or another health care facility beyond the discharge time recommended by your physician or authorized by Anthem's Precertification.

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

Contraceptive Services. Except as stated in Section 7, II, A, "family planning," no Benefits are available for office visits, consultations, examinations or any other Outpatient service related to contraceptive drugs, devices or methods. No Benefits are available under this Benefit Booklet for the purchase of contraceptive drugs or devices. No Benefits are available for nonprescription contraceptives or services related to nonprescription contraceptives. Examples of noncovered services are: contraceptive creams and foams, condoms, spermicidal jelly or contraceptive sponges. *Please contact the State of New Hampshire's pharmacy benefit administrator for information about coverage for contraceptive drugs and devices.*

Convenience Services. No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the services are furnished, ordered or prescribed by a Designated Provider. Noncovered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges.

Cosmetic Services. No Benefits are available for Cosmetic Services. The cost of care related to, resulting from, arising from or medical conditions caused by or provided in connection with Cosmetic Services is not covered. No Benefits are available for care furnished for complications arising from Cosmetic Services. Cosmetic Services include but are not limited to any care, procedure, service, equipment, supplies or medications primarily intended to change your appearance, to improve your appearance or furnished for psychiatric or psychological reasons. For

example: surgery or treatments to change the texture or appearance of your skin are not covered. No Benefits are available for surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except for the covered surgery described in Section 7, VI, "Surgery."

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

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

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

Domiciliary Care. Domiciliary care is care provided in a residential institution or setting, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included. Domiciliary care is Custodial Care and is not covered under any portion of this Benefit Booklet.

Educational, Instructional, Vocational Services and Developmental Disability Services. Except as stated in Section 7, II, A, "diabetes management programs" and "nutrition counseling" no Benefits are available for educational or instruction programs or services. Noncovered services include, but are not limited to education evaluation, testing, classes, therapy, tutoring, counseling, programs, equipment or supplies. No Benefits are available for vocational/occupational evaluations, testing, classes, therapy, counseling, programs, equipment or supplies. Except as stated in Section 7, V "Behavioral Health Care," no Benefits are available for services, counseling, therapy, supplies, equipment or programs for behavioral reasons or for Developmental Disabilities. No Benefits are available for early childhood intervention programs.

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

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

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

- The service cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency and such final approval has not been granted; or
- The service has been determined by the FDA to be contraindicated for the specific use; or
- The service is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- The service is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- The service is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

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

- The scientific evidence is not conclusory concerning the effect of the service on health outcomes;
- The evidence does not demonstrate that the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence does not demonstrate that the service has been shown to be as beneficial for the total

population for whom the service might be proposed as any established alternatives; and

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

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

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

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

You have the right to appeal Benefit determinations made by Anthem, including Adverse Determinations regarding Experimental/Investigational services. Please see Section 11 for complete information.

Food and Food Supplements. Except as required by applicable law, no Benefits are available for foods, food supplements or for vitamins. Please see Section 7, IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics," for information about Benefits for some of these items. *Please contact the State of New Hampshire's pharmacy benefit administrator for information about coverage that may be available for some of these services.*

Foot Care (Routine), Foot Orthotics and Therapeutic/Corrective Shoes. No Benefits are available for routine foot care. Services or supplies in connection with corns, calluses, flat feet, fallen arches, weak feet or chronic foot strain are not covered. No Benefits are available for foot orthotics, inserts or support devices for the feet. Except as described in Section 7, IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics," therapeutic/corrective shoes are not covered.

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

Government Programs. Benefits are not available for Covered Services to the extent that benefits for such services are paid or payable (or could reasonably be expected to be payable if a claim were made) under any of the following:

- Medicare or any other federal, state or local government program for which the government is the primary payer, including CHAMPUS/TRICARE. Exception: Benefits are available under this Benefit Booklet even though you may be eligible for Medicaid.
- Any federal, state, county, municipal, or other government agency, including Medicare and the Veteran's Administration, for service-connected disabilities

Please see Section 10 for more information regarding Medicare.

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

Missed Appointments. Physicians and other providers may charge you for failing to keep scheduled appointments without giving reasonable notice to the office. No Benefits are provided for these charges. You are solely responsible for the charges.

Non-Hospital Institutions. No Benefits are available for care or supplies in any facility that is not specifically stated as a covered facility in this Benefit Booklet. No Benefits are available for care or supplies in convalescent homes or similar institutions and facilities that provide primarily custodial, maintenance or rest care. No Benefits are available for care or supplies in health resorts, spas, sanitariums, sanatoriums or tuberculosis hospitals.

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

Pharmacy Services. No Benefits are available under this Benefit Booklet for prescription drugs purchased at a retail or mail service pharmacy, doctor's office or facility for "take home" use. Except as specifically stated in this Benefit Booklet, no Benefits are available for any drug, medication, supply, equipment, device, service or care furnished by a pharmacy. *Please contact the State of New Hampshire's pharmacy benefit administrator for information about coverage for pharmacy services.*

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

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

Processing Fees. No Benefits are available for the cost of obtaining medical records or other documents.

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

Reversal of Voluntary Sterilization. No Benefits are provided for the reversal of sterilization, including infertility treatment that is needed as a result of a prior elective or voluntary sterilization (or elective sterilization reversal) procedure.

Sclerotherapy for Varicose Veins and Treatment of Spider Veins. No Benefits are available for sclerotherapy for the treatment of varicose veins of the lower extremities including, but not limited to, ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. No Benefits are available for the treatment of telangiectatic dermal veins (spider veins) by sclerotherapy or any other method. Charges for injection of sclerosing solution for varicose veins are not covered.

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

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

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

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

Surrogate Parenting. Costs associated with surrogate parenting or gestational carriers are not covered. For other related exclusions, please see "Infertility Diagnostic Services" in Section 7, VI, C.

Transportation. No Benefits are available for transportation costs, except as described in Section 7, II "Ambulance" and VI, "Organ and Tissue Transplants."

Weight Control. Except as stated in Section 7, II, A, "Preventative Care" (nutritional counseling and diabetes management), and Section 7, VI, G, "Surgery" (surgery for weight loss or weight management), no Benefits are available for any service, care, procedure or program for weight or appetite control, weight loss, weight management or for control of obesity even if the weight or obesity aggravates another condition. This limitation applies even if the services are furnished or prescribed by a Designated Provider and even if the service meets Anthem's definition of Medical Necessity and/or health complications arising from the obesity are documented.

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

X-rays. No Benefits are available for diagnostic x-rays in connection with research or study, except as explained for routine patient care costs in Section 7, VI, "Qualified Clinical Trials." and VI, A "Dental Services." No Benefits are available for orthopantagrams.

Section 9: Claim Procedure

Please see Section 14 for definitions of specially capitalized words.

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

I. Post-Service Claims

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

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

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

If services are furnished by a Nonparticipating Provider, you may need to submit your own claim form. Please contact the State of New Hampshire Division of Personnel or Anthem to obtain the correct claim form as prescribed by Anthem for submission. Anthem's toll-free telephone number is shown on your identification card. Please complete the claim form, include your itemized bill and any information about other insurance payment and submit the claim to the address indicated on the claim form.

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

II. Pre-Service Claims

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

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

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

- An **Urgent Care Claim** means a request for Precertification submitted as *required* under this Benefit Booklet, for care or treatment with respect to which the application of time periods for making non-urgent Pre-Service Claim determinations:
- Could seriously jeopardize your life or health or your ability to regain maximum function, or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the proposed care or treatment.

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

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

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

You will be given at least 45 days from receipt of the notice to provide the specified information. The determination will be made as soon as possible, but in no case later than 15 days after the earlier of 1) receipt of the specified information by Anthem, or 2) the end of the period afforded to you to provide the specified information.

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

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

No fees for submitting a Pre-Service Claim will be assessed against you or your authorized representative. You may authorize a representative to submit or pursue a Pre-Service Claim or Benefit determination by submitting your written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact the Customer Service phone number shown on your identification card.

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

III. Notice of a Claim Denial

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

- The specific reason(s) for the determination, including the specific provision of your plan on which the determination is based,
- A statement of your right to access the internal appeal process and the process for obtaining external review. In the case of an Urgent Care Claim Denial or when the denial is related to continuation of an ongoing course of treatment for a person who has received emergency services, but who has not been discharged from a facility, Anthem will include a description of the expedited review process,
- If the Claim Denial is based upon a determination that the claim is Experimental or Investigational or not Medically Necessary or appropriate, the notice will include:
 1. The name and credentials of Anthem's Medical Director, including board status and the state(s) where the Medical Director is currently licensed. If a person or other licensed entity making the Claim Denial is not the Medical Director but a designee, the designee's credentials, board status, and state(s) of current license will be included, and
 2. An explanation of the clinical rationale or the scientific judgment for the determination. The explanation will recite the terms of your plan or of any clinical review criteria or internal rule, guideline, protocol or other similar provision that was relied upon in making the denial and how these provisions apply to your specific medical circumstances.
- If an internal guideline (such as a rule, protocol, or other similar provision) was relied upon in making the Claim Denial, a statement that such guideline was relied upon. A copy of the guideline will be included with the notice, or you will be informed that a copy is available free of charge upon request,
- If clinical review criteria were relied upon in making any Claim Denial, the notice will include a statement that such criteria were relied upon. The explanation of any clinical rationale will be accompanied by the following notice: "The clinical review criteria provided to you are used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the Benefits covered under your Benefit Booklet."

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

IV. Appeals

Please see Section 11 for complete information about the Appeal Procedure.

V. General Claim Processing Information

Note: This section only applies after Medicare has processed the claim.

Anthem Participating Provider or BlueCard Provider Services. When you receive Covered Services from an Anthem Participating Provider or from a BlueCard Provider, you will not have to fill out any claim forms. Simply identify yourself as a Member and show your Anthem identification card before you receive the care. Anthem Participating Providers and BlueCard Providers will file claims for you. Eligible Benefits will be paid directly to Anthem Participating or BlueCard Providers.

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

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

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

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

Nonparticipating Provider Services. When you receive a Covered Service from a Nonparticipating Provider in New Hampshire or a nonBlueCard Provider, you may have to fill out a claim form. You can get claim forms from Anthem's Customer Service Center. The toll-free telephone number is on your identification card. Mail your completed claim form to Anthem, along with the original itemized bill.

Nonparticipating New Hampshire Providers and nonBlueCard Providers may ask you to pay the entire charge at the time of your visit. It is up to you to pay the provider. Generally, Anthem will pay eligible Benefits directly to you. Benefits equal the Maximum Allowable Benefit. You may be responsible for amounts that exceed the Maximum Allowable Benefit.

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

Services Outside the United States of America. When you are traveling outside of the country, you will only be covered for urgent/emergent care (please see Section 6 for more information about urgent and emergency care). If you are in need of urgent/emergent care while traveling outside the United States, Puerto Rico, and the Virgin Islands, call the BlueCard Worldwide Center at 1-800-810-BLUE (2583) for assistance in locating a health care provider. In order to submit out-of-country claims, you must obtain itemized bills translated to English. Charges for Covered Services should be stated in terms of United States currency. To determine the United States currency amount, please use the exchange rate, as it was on the date you received the care. There is no benefit for out of country services that do not meet urgent or emergent care criteria.

Section 10: Other Party Liability

Please see Section 14 for definitions of specially capitalized words.

Please Call Customer Service at the toll-free number shown on your identification card and ask for the coordination of benefits operator if you have questions about any portion of this Section.

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

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

For purposes of Benefits under this Medcomp Three Benefit Booklet, Medicare shall be deemed to be Primary for Medicare Eligible Expenses.

I. Coordination of Benefits (COB)

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

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

- Group or individual hospital, surgical, medical or major medical coverage provided by Anthem Blue Cross and Blue Shield (Anthem), a private insurer or an insurance company, an HMO, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured), a prepayment group or individual practice plan, or a prepayment plan of any other organization. COB applies to any coverage including self-insured, self-funded or unfunded benefit plans or plans administered by a government, such as "socialized medicine" plans. COB also applies to union welfare plans, employee or employer benefit organizations, or any other insurance that provides medical benefits. COB will apply to dental coverage to the extent agreed upon between the State of New Hampshire, Anthem and the dental benefit administrator;
- Except as stated in this Section, any insurance policy, contract or other arrangement or insurance coverage, where a health Benefit is provided, arranged or paid, on an insured or uninsured basis,
- Any coverage for students sponsored by, provided through or insured by a school, sports program or other educational institution above the high school level except for school accident type coverage.

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

C. The term "health care plan or policy" will be interpreted separately with respect to:

- Each policy, contract or other arrangement for benefits or services; or

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

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

Please remember that related to services that are not covered under this Benefit Booklet are your responsibility Whether Anthem is the Primary or the Secondary plan. Also, plan rules apply as stated in this Section whether Anthem is the Primary or the Secondary plan. For example, any applicable provider network rules apply.

II. Definitions

The following definitions apply to the terms of the Section:

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

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

Note: when coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules indicated in III (below) of this Section will be used to determine how benefits will be coordinated.

Allowable Expense means a health care service expense that is eligible for Secondary Benefits under this health care plan. Allowable Expenses include, but are not limited to, to any deductible, coinsurance and copayment cost shares required under a Primary plan. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered to be the benefit available under that plan.

The following limitations apply to Allowable Expenses:

- An expense must be for a Medically Necessary Covered Service, as defined in this Benefit Booklet. Otherwise, no portion of the expense is an Allowable Expense.
- When the Primary plan has provided full benefits and there is no Member liability for claim payment, no portion of the expense is an Allowable Expense.
- When the Primary plan has provided benefits and there is Member liability for claim payment, the following rules apply to Secondary coverage under this plan:
 1. If all plans covering the claim compute benefits or services based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for the specific claim is not an Allowable Expense.
 2. If all plans covering the claim compute benefits or services based on a negotiated fee, any amount in excess of the highest negotiated fee for the specific claim is not an Allowable Expense.

3. If one plan computes benefits or services for a claim based on a usual and customary fee, relative value schedule reimbursement methodology or other similar reimbursement methodology and another computes benefits or services based on a negotiated fee, the Primary plan's payment arrangement shall be the Allowable Expense for all plans. Exception: If an Anthem Participating Provider contracts with Anthem to accept a negotiated amount as payment in full when Anthem is the Secondary payer and such negotiated amount differs from the Primary payer's arrangement, Anthem's negotiated amount will be the Allowable Expense used to determine Secondary Benefits. The total amount in payments and/or services provided by all payers combined will not exceed Anthem's Maximum Allowable Benefits.
- If the Primary plan bases payment for a claim on the provider's full charge and does not utilize usual and customary fees, relative value schedule reimbursement methodologies, other similar reimbursement methodologies and does not negotiated fees with providers, the combination of benefits paid by the Primary plan and this plan will not exceed Anthem's Maximum Allowable Benefit. The difference between Anthem's Maximum Allowable Benefit and the provider's charge is not an Allowable Expense.
 - When benefits are reduced under a Primary plan due to an individual's failure to comply with the Primary plan's provisions, the amount of the reduction is not an Allowable Expense.
 - Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

III. The Order of Payment is Determined by COB

COB uses the following rules to determine the Primary and Secondary payers when you are covered by more than one health care plan or policy.

A. Important General Rules:

- **Medicare Program.** Medicare Secondary Payer (MSP) laws determine whether Medicare benefits will be Primary or Secondary to the Benefits available under this Benefit Booklet or any rider, endorsement or other amendment to this Benefit Booklet. Factors that determine which plan is Primary include, but are not limited to: the number of individuals employed by the State of New Hampshire, your status as an active employee, your age and the reason that you are eligible for Medicare. If Medicare is the Secondary plan according to MSP laws, coverage under this Benefit Booklet is Primary. If Medicare is the Primary plan according to MSP laws, the State of New Hampshire coverage for which you are eligible is Secondary.

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

- To the extent permitted by applicable law, when any Benefits are available as Primary Benefits to a Member under Medicare or any Workers' Compensation Laws, Occupational Disease Laws and other employer liability laws, those Benefits will be Primary.
- If you have coverage under this plan and any plan outside the U.S.A. (including plans administered by a government, such as "socialized medicine" plans), the out-of-country plan is Primary when you receive care outside the U.S.A. This plan is Primary when you receive services in the U.S.A. This rule applies before any of the following rules.
- Except for group coverage that supplements a basic part of a benefit package and provides supplementary

coverage (such as major medical coverage superimposed over base hospital/surgical coverage) any health care plan or policy that does not contain a coordination of benefits provision consistent with the terms of this Section is always Primary.

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

- **Active Employee or Retired or Laid-off Employee.** The plan that covers a Member as an active employee (that is - an employee who is neither laid off nor retired) is Primary. The plan covering that same Member as a retired or laid-off employee is Secondary. The same rule applies if a Member is a dependant of an active employee and that same Member is a dependant of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **COBRA or State Continuation Coverage.** If a Member is covered under a health care plan or policy pursuant to a “right of continuation” law (such as COBRA) or under New Hampshire law, and the Member is also covered under a plan that is not provided pursuant to a “right of continuation” law, the “right of continuation” health care plan is Secondary. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage.** The Plan that covered the person as an employee, Member, policyholder, Subscriber or retiree longer is Primary and the plan that covered the Member the short period of time is Secondary.

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

IV. Workers' Compensation

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

V. Subrogation and Reimbursement

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

Benefits will be provided for medical care paid, payable or required to be provided under this Benefit Booklet, and the Benefits paid, payable or required to be provided. Anthem must be reimbursed by the Member for such payments as permitted under applicable law from medical payments coverage and other property and casualty insurance including but not limited to automobile and homeowners insurance coverage.

Anthem may reduce any Benefit paid, payable or required to be paid under this Benefit Booklet by the amount that the Member has received in payment from medical payments coverage and other property and casualty insurance including but not limited to automobile and homeowners insurance coverage.

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

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

- Anthem may pursue its subrogation rights for the full amount of Benefits Anthem has paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Anthem to exercise the rights set forth in this Section and do nothing to prejudice such rights.
- Anthem has the right to take whatever legal action is seen fit against any party or entity to recover Benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Anthem's subrogation claim and any claim still held by you, Anthem's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- Anthem is not responsible for any attorney fees, other expenses or costs you incur without the prior written consent of Anthem.

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

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

- Anthem is entitled to full reimbursement from any Recovery, notwithstanding any allocation made in a settlement agreement or court order, and even if the Recovery does not fully satisfy a judgment, settlement or underlying claim for damages or fully compensate or make you whole.
- You and your legal representative must hold in trust for Anthem the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Anthem immediately upon your receipt of the Recovery. You must fully reimburse Anthem, without any set-off or reduction for attorney fees, other expenses or costs.

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

- A. You fail to disclose to Anthem the amount of your Recovery,
 - B. The amount Anthem paid on your behalf is not repaid or otherwise recovered by Anthem, and/or
 - C. You fail to cooperate with Anthem.
- Anthem shall also be entitled to recover any of the unsatisfied portion of the amount paid by Anthem or the amount of your Recovery, whichever is less, directly from the providers to whom payments have been made. In such a circumstance, it may then be your obligation to pay the provider the full amount billed by the provider, and Anthem would have no obligation to pay the provider.

VI. Anthem's Rights Under this Section

Anthem reserves the right to:

- Take any action needed to carry out the terms of this Section,
- Exchange information with your other insurance company or other party,
- Recover Anthem's excess payment from another party or reimburse another party for its excess payment, and
- Take these actions when Anthem decides they are necessary without notifying the Member.

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

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

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

Anthem's recovery rights. The State of New Hampshire grants to Anthem the sole right to pursue recovery of paid claims administered on behalf of enrollees under this agreement. Anthem shall establish recovery policies, determine which recoveries are to be pursued, initiate and pursue litigation when it deems this appropriate, incur costs and expenses and settle or compromise recovery amounts. Anthem will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. If Anthem would recover the overpayment amount through an automatic recoupment mechanism, Anthem will not pursue such recovery if the overpayment was in the amount of twenty-five dollars (\$25.00) or less. If Anthem would recover the overpayment amount through manual recovery, Anthem will not pursue such recovery if the overpayment was in the amount of seventy-five dollars (\$75.00) or less. The State of New Hampshire and Anthem agree that Anthem shall not initiate overpayment recovery efforts more than 18 months after a payment was received by a physician.

VII. Your Agreement and Responsibility Under This Section

You have the responsibility to provide prompt, accurate and complete information to Anthem about other health coverage and/or insurance policies or benefits you may have in addition to Anthem coverage. Other health coverage, insurance policies or benefits include, but are not limited to, benefits from other health coverage, Worker's Compensation, and/or claims against liability or casualty insurance companies arising from any injury, illness, impairment or medical condition you receive. By accepting this Benefit Booklet, you agree to cooperate with Anthem, and you agree to provide information about any other health coverage on an annual basis or when necessary to carry out the terms of this Section.

By accepting this Benefit Booklet, you must:

- Promptly notify Anthem of how, when and where an accident or incident resulting in personal injury, illness, impairment or medical condition to you occurred and all information regarding the parties involved,
- Cooperate with Anthem in the investigation, settlement and protection of rights,
- Not do anything to prejudice the rights of Anthem,
- Send to Anthem copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury, illness, impairment or medical condition to you, and/or

Promptly notify Anthem if you retain an attorney or if a lawsuit is filed on your behalf. Any action which interferes with Anthem's under this Section or the Benefit Booklet may result in the termination of coverage for the Subscriber.

Section 11: Member Satisfaction Services and Claim Appeal Procedure

Please see Section 12 for definitions of specially capitalized words.

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

I. Member Satisfaction Services

Appealing Medicare Decisions. With few exceptions, Benefits are available under this Benefit Booklet only after Medicare determines that your services are covered. If Medicare reduces or denies Medicare benefits, please contact Medicare for assistance first. Medicare's grievance procedure is described in the "Explanation of Medicare Benefits" form issued to you by Medicare. You must use the Medicare grievance procedure to appeal any decision made by Medicare. Anthem does not review Medicare decisions. If Medicare changes a decision about Medicare coverage, please notify Anthem. Anthem's Customer Service representatives are available to assist you in applying for any additional supplemental Benefits that may be available under this Benefit Booklet.

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

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

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

Anthem will respond to most of your questions or requests at the time of your call or within a few days. Please see "Internal Appeal Procedure" (below) for complete information. You may have other remedies, as summarized below in this Section.

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

Please contact **Anthem's Customer Service Center** about your membership, Benefits, Covered Services, plan materials, the network or an Anthem Participating Provider. Anthem's toll free telephone number is on your identification card. Or, you may write to: **Customer Service Center, Anthem Blue Cross and Blue Shield, P.O. Box 660, North Haven, CT 06473-0660**. For more information about Member services, please visit Anthem's website at www.anthem.com.

You may contact the State of New Hampshire Division of Personnel for assistance.

II. Internal Appeal Procedure

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

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

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

- You submit a written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact the Customer Service phone number on your identification card. Exception: For Urgent Care Claim appeals, Anthem will consider a health care professional with knowledge of your condition (such as your treating physician) to be your authorized representative without requiring your written acknowledgment of the representation, or
- A court order is in effect authorizing the person to act on your behalf and a copy of the order is on file with Anthem.

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

- Bills that you have received from the provider, and
- Any information that you believe is important for review, such as statements from your physician or letters you received from Anthem.
- You may point out the portion of this Benefit Booklet that you believe pertains to your appeal. You should state the outcome you are expecting as a result of your appeal.

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

A. Internal Appeal Process:

- **First Level Internal Appeal Process.** You may call or write to initiate an internal appeal. Letters should be addressed to:

**Appeal Analyst – First Level
Anthem Blue Cross and Blue Shield
P.O. Box 518,
North Haven, CT 06473-0518**

Your appeal must be submitted within 365 days of Anthem’s first notification about the issue that caused you to appeal.

- **Second Level Internal Appeal** - If you are not satisfied with the result of your first level internal appeal, you or your authorized representative may appeal further. Second level internal appeals should be addressed to:

**Appeal Coordinator Second Level
Anthem Blue Cross and Blue Shield
P.O. Box 518
North Haven, Connecticut 06473-0518**

Your appeal must be in writing unless Anthem determines that it is not reasonable to require a written statement. For example, Expedited Appeals may be submitted orally or in writing. Your appeal must be submitted within at least 180 days of the notice stating the results of your first level internal appeal. You do not have to re-send the information that you submitted for your first level internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

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

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

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

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

- **Nonexpedited Pre-Service Claim Appeals** - Anthem will make a decision and notify you within a reasonable time appropriate to your medical circumstances, but in no event more than 15 days.
- **Post-Service Claim Appeals** - Anthem will make a decision and notify you within a reasonable time appropriate to your medical circumstances, but in no event more than 30 days.

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

- The specific reason(s) for the determination, including reference to the specific provision of this Benefit Booklet or plan on which the determination is based,
- If an internal rule, guideline, protocol or other similar provision was relied upon in making the claim denial, a statement that such a rule, guideline, protocol or other similar provision was relied upon,

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

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

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

- The person(s) reviewing your appeal will not be the same person(s) who made the initial Claim Denial or a subordinate or supervisor of the person who made the initial Claim Denial,
- In the appeal of a Claim Denial based in whole or in part on a medical judgment, including determinations with regard to whether a service is Experimental, Investigational or not Medically Necessary or appropriate, the appeal will be conducted by or in consultation with a health care professional in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition of health problem in question. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question, in addition to expertise treating similar complications of those problems.
- Also in the appeal of a Claim Denial based in whole or in part on a medical judgment, Anthem's decision notice will include the titles and qualifying credentials of the person conducting the review. At your request, the identity and qualifications of any medical or vocational expert whose advice was considered in making the initial Claim Denial (without regard to whether it was relied upon) will be provided.
- Anthem adheres to the timeliness within which you must file a First or Second Level Internal Appeal. Timelines are stated in subsection II, above.
- You may submit written comments, documents, records, and other information relating to your appeal, without regard to whether those documents or materials were considered in making the initial Claim Denial,
- You will be provided, upon request and without charge, reasonable access to and copies of all documents, records, and other information relevant to or considered in making the initial Claim Denial,
- Your issue will be considered anew (de novo), as if the issue had not been reviewed before and as if no decision had been previously rendered. All information, documents, and other material submitted for the

internal appeal procedure will be considered without regard to whether the information was considered in making a Claim Denial.

In addition to the internal appeal procedure described above, you may have the right to an Independent External Review of an Adverse Determination. Please see III (below) for complete information.

By accepting this Benefit Booklet, you agree that you will take no civil or legal action related to your appeal before completing the internal appeal procedure. Your obligations under this Benefit Booklet are fulfilled when the internal appeal procedure is completed.

III. Voluntary External Review

Voluntary External Review. If the outcome of the second level internal appeal is adverse to you and is not administrative in nature (i.e. related to eligibility, benefit coverage limits or a plan exclusion), you may be eligible for an independent External Review.

Note: Your decision to seek an independent External Review is voluntary. This is not an additional step that you must take in order to fulfill your appeal procedure obligations described in II (above). Your decision to seek External Review will not affect your rights to any other Benefits under this health care plan. There is no charge for you to initiate an independent External Review.

A. Eligibility. At your request and subject to all the terms of this subsection, Anthem will arrange for an independent External Review to be conducted by an Independent Review Organization (IRO) comprised of persons who are not employed by Anthem or any of its affiliates. You are eligible for an independent External Review, provided that:

- You have completed the internal appeal process described in II above, and
- The outcome of the Second Level Appeal is an Adverse Determination, such as Anthem's reduction or denial of Benefits based on failure to meet the definition of Medical Necessity or because a service is found by Anthem to be an Experimental/Investigational Service, and
- The service under appeal is a Covered Service or would be covered if certain clinical conditions were met, and
- The service is not subject to an exclusion or limitation or a Benefit maximum as stated in this Benefit Booklet, and
- Your review request is not for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence or other professional fault.

You must submit your request for External Review to Anthem within 180 days of Anthem's notice stating the results of your internal appeal. Otherwise, your option to seek an independent External Review under this subsection is not available.

B. To request an independent External Review of an Adverse Determination:

Address letters to:

**Anthem Blue Cross and Blue Shield Appeal Analyst – External Review
Anthem Blue Cross and Blue Shield
PO Box 518
North Haven, CT 06473-0518**

Your request must be in writing unless Anthem determines that it is not reasonable to require a written statement. For example, requests for Expedited External Review may be submitted orally or in writing. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

C. Timeframes for Independent External Review. Upon receipt of your request for External Review, Anthem will select an Independent Review Organization (IRO) to conduct the review and will forward to the IRO your request, Anthem’s documentation from your internal appeal and any new information you have submitted for review. The IRO will review the request and provide a response within 30 days of receiving it.

You may request an Expedited External Review if Anthem determines that you would be significantly harmed by the standard External Review process set forth above. For Expedited External Review requests, you must provide a statement verifying that the standard External Review process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. In most cases, Expedited External Reviews will be completed within three days of receipt of the request.

If you submit new information for External Review which was not previously submitted and reviewed by Anthem, Anthem has the right to review the new information and reverse its prior coverage determinations. If Anthem reverses the prior coverage determinations, you will be notified in writing and Anthem shall not be obligated to pursue External Review any further.

D. The decision of the External Review Organization will be binding upon the State of New Hampshire, and will be binding upon Anthem. It is also binding upon you, except to the extent that you have other remedies available under applicable law.

IV. Disagreement With Recommended Treatment

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

V. Appeal Outcomes

Because the State of New Hampshire benefit program is self-funded, the New Hampshire Insurance department does not regulate Anthem in its administration of this coverage. If you are not satisfied with the outcome of your internal appeal or independent External Review, or if you believe at any time that Anthem is not following the appeal process as described in this Section or in your communications with Anthem, you should contact the State of New Hampshire Division of Personnel for assistance.

Section 12: General Provisions

Please see Section 14 for definitions of specially capitalized words.

Anthem's Responsibility to Notify The State of New Hampshire About Changes - If we change the provisions of this Benefit Booklet, The State of New Hampshire will be given reasonable notice before the effective date of the change. Anthem will provide the State of New Hampshire with at least 30 days prior notice in the event of any renewal premium rate increase.

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

- **Waiver of Benefit Booklet Provisions** - Neither the waiver by Anthem hereunder of a breach of or a default under any of the provisions of this Benefit Booklet, nor the failure of Anthem, on one or more occasions, to enforce any of the provisions of this Benefit Booklet or to exercise any right or privilege hereunder, will thereafter be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any of such provisions, rights or privileges hereunder.
- **Applicable Law** - This Benefit Booklet, the rights and obligations of Anthem and Members under this Benefit Booklet, and any claims or disputes relating thereto, will be governed by and construed in accordance with the laws of New Hampshire. This Benefit Booklet is intended for sale in the State of New Hampshire. Your Benefit Booklet is intended at all times to be consistent with the laws of New Hampshire. If New Hampshire laws, regulations or rules require Anthem to provide Benefits that are not expressly described in this Benefit Booklet, then this Benefit Booklet is automatically amended only to the extent specified by the laws, regulations or rules that are enacted by the State of New Hampshire. Anthem may adjust premium requirements to reflect additional Benefit requirements that are mandated by the State of New Hampshire.

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

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

Anthem, or anyone acting on Anthem's behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the Benefit Booklet. This includes, without limitation, the power to construe the Benefit Booklet and other contract agreements, to make determinations about questions arising under the Benefit Booklet and other contract agreements to make, develop, establish and amend the medical policy, internal guidelines, rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Benefit Booklet and other contract agreements. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Benefit Booklet, Provider agreements, and applicable state or federal laws. This Benefit Booklet shall be construed so that a specific limitation or exclusion will override more general Benefit language.

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

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

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

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

Acknowledgment of Understanding - By accepting this policy, you expressly acknowledge your understanding that this policy constitutes a benefit plan provided through the State of New Hampshire by agreement with 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 license permits Anthem and Matthew Thornton Health Plan to use the Blue Cross and Blue Shield service marks in the State of New Hampshire. The Plan is not contracting as an agent of the Blue Cross and Blue Shield Association.

Section 13: Membership Eligibility, Termination of Coverage and Continuation of Group Coverage

Please see Section 14 for definitions of specially capitalized words.

I. Eligibility

Coverage under this Plan is made available to you as a Subscriber because of your retirement from the State of New Hampshire. Coverage is available only to Retirees who are enrolled in Parts A and B of Medicare and who the State of New Hampshire determines are eligible under the Plan in accordance with their applicable rules and procedures. Coverage is provided on a Subscriber only basis. **If you have other family members (for example, a spouse or dependents) contact the State of New Hampshire Division of Personnel about coverage eligibility.**

Who Is Covered Under This Benefit Booklet? You, the Subscriber are covered under this Benefit Booklet.

When Coverage Begins. Your coverage begins on the effective date determined by the State of New Hampshire. You should contact the State of New Hampshire Division of Personnel for information about your effective date.

Special Enrollees. *Please contact the State of New Hampshire Division of Personnel for information about health care coverage for the following events:*

Special Enrollees are employees and/or eligible dependants who did not enroll when first eligible and who experience one of the Special Enrollee events listed below. Special Enrollees are not required to wait until a State of New Hampshire open enrollment period to enroll in this health plan, provided that the terms stated below are met. Special Enrollee events are:

1. **Loss of eligibility for other coverage.** This event applies when an employee or an eligible dependant loses other public or private health care coverage, provided that the person was covered under the other plan at the time he or she was first eligible to enroll in this plan and he or she declined enrollment in this plan when first eligible. Provided that you enrolled within 30 days after eligibility for other coverage is lost, this Benefit Booklet will become effective on the date of the event.

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

- Voluntary or involuntary termination of the other health care coverage (including exhaustion of periods of coverage under continuation laws, such as COBRA and whether or not such continuation options exist),
- Loss of eligibility due to voluntary or involuntary termination of employment or eligibility,
- Loss of eligibility due to a reduction in work hours,
- Loss of eligibility due to legal separation, divorce, the death of a spouse or a dependant otherwise loses eligibility (for example: a child attains an age that causes him or her to lose eligibility status in another plan, but the child is eligible to enroll in this health care plan),
- Employer contributions toward the other coverage end (regardless of whether the person is still eligible for the other coverage),

- For a person covered under an individual HMO policy that does not provide benefits to individuals who no longer reside, live or work in the service area, loss of eligibility occurs when the individual loses coverage because he or she no longer resides, lives or works in the service area. For a person with group HMO coverage, the same rule applies, provided that there is no other coverage offered by the other health care plan,
- Loss of eligibility because the other plan ceases to offer health care benefits to a class of similarly situation individuals,
- In a multiple-option group plan, an issuer or insurer providing one of the options ceases to operate in the group market (exception: this provision does not apply if the group plan provides a current right to enroll in alternative coverage),

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

2. **Court ordered enrollment.** This event applies when a court has ordered coverage for a spouse or dependant child under an employee's health care plan. Provided that you enroll within 30 days after the court order is issued, this Benefit Booklet will become effective on the date of the event. *Please contact the State of New Hampshire Division of Personnel for information about coverage eligibility.*
3. **New dependant due to marriage or civil union.** Employees and eligible dependants who are not covered under this health plan may be eligible due to lawful marriage or lawful civil union at the same time as the new spouse. *Please contact the State of New Hampshire Division of Personnel for information about coverage eligibility.*
4. **New dependant due to birth, adoption or placement for adoption.** Employees and/or spouses and other eligible dependants who are not covered under this health plan may enroll at the same time as a newborn child, adopted child or a child placed in your home as the adoptive parent during the waiting period before adoption. Provided that the child is enrolled within 30 days of the birth, adoption or placement, this Benefit Booklet will become effective on the date of the birth, adoption or placement. *Please contact the State of New Hampshire Division of Personnel for information about coverage eligibility.*

Effective Date for Benefits - The effective date of your coverage under this Benefit Booklet is determined by the State of New Hampshire. After your coverage under this Benefit Booklet begins, Benefits are available according to the coverage in effect on the "date of service."

- For Inpatient hospital *facility* charges, the date of Inpatient admission is the date of service. However, for *professional* services (such as Inpatient medical care or surgery furnished by a physician), the date of service is the date you receive the care.
- For Professional maternity care, (prenatal care, delivery of the baby and post partum care), the date of service is the date of delivery, provided that the total maternity care was furnished by one provider.
- For Outpatient services (such as emergency room visits, Outpatient hospital care, office visits, physical therapy or Outpatient surgery, etc.), the date of service is the date you receive the care.

Persons Not Eligible for Membership. You must meet the eligibility rules of the State of New Hampshire and the terms set forth by Anthem in this Benefit Booklet to be eligible for membership.

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

It is your responsibility to inform the State of New Hampshire of changes in your name or address. It is also your responsibility to inform the State of New Hampshire if you need to add a Member to your coverage (i.e. marriage, birth, adoption, etc.) or when a Member is no longer eligible for coverage (i.e. divorce, legal separation, dependant ages out, etc.) under your Benefit Booklet.

Notice requirements regarding continuation of coverage election are stated in III (below), “Continuation of Group Coverage.”

Contact the State of New Hampshire, Division of Personnel to make membership changes and name changes.

Disclosing Coverage. As another condition of membership, you agree to provide information to Anthem regarding any other health coverage (including Medicare) under which you may be entitled to Benefits. Your receipt of benefits through another health care plan may affect your Benefits under this Benefit Booklet. Please see Section 10 “Other Party Liability” for more information about how Benefits are determined when you are covered under more than one health insurance plan.

II. Termination of Coverage

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

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

Please see III (below), “Continuation of Group Coverage” for information about coverage options.

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

Termination or Renewal of the Group Contract - Coverage under this Benefit Booklet is provided under the terms of a contract between Anthem and the State of New Hampshire. The agreement is effective for a fixed term. At the time of the State of New Hampshire’s anniversary date or at a special open enrollment period agreed upon by Anthem and the State of New Hampshire, Anthem will renew the group agreement at the option of the State of New Hampshire, except for the following reasons:

- Nonpayment of required premiums - Coverage will terminate on a date stated in a notice mailed by Anthem to the State of New Hampshire if Anthem does not receive payment on time from them. Cancellation for nonpayment is considered cancellation by the State of New Hampshire and the Subscriber, and not by Anthem.
- The State of New Hampshire fails to meet Anthem’s minimum employee participation requirements. Notice of cancellation or nonrenewal for failure to meet minimum participation requirements will be delivered to the State of New Hampshire by Anthem, (or mailed to the State of New Hampshire’s most current address, as shown on Anthem’s records) at least 30 days before the effective date of the cancellation or nonrenewal.
- Fraud or intentional misrepresentation on the part of an individual or an individual’s representative or on the part of an employer, employee, or an employee’s representative.

- The State of New Hampshire restricts eligibility to participants in this health plan based on an applicant's medical history or otherwise violates applicable state or federal law regarding medical underwriting,
- Anthem ceases to offer coverage in the large employer market, and has provided notification to the New Hampshire Insurance Department of such action and is otherwise in accordance with New Hampshire law regarding such action.

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

Please note: The State of New Hampshire or Anthem may, at the time of renewal, modify the health care plan offered to State of New Hampshire retirees.

If You Are No Longer eligible for the State of New Hampshire retiree benefit plan. If your membership terminates, your coverage will terminate on a date as determined by the State of New Hampshire. Please see III (below), "Continuation of Group Coverage" for information about coverage options.

On Your Death. Your coverage will terminate on the date of your death. Please see III (below), "Continuation of Group Coverage" for information about coverage options.

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

- Anthem may not renew a Subscriber's coverage for fraud committed by the Subscriber in connection with information provided at enrollment or with any claim filed for Benefits.
- Anthem may not renew a Subscriber's coverage upon 30 days advance written notice if an unauthorized person is allowed to use the Subscriber's identification card or if Subscriber otherwise cooperates in the unauthorized use of another individual's identification card.

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

III. Continuation of Group Coverage

Certain Provisions of law affect your rights to continue coverage when group coverage would otherwise end or obtain other coverage. Common examples of such laws and other options are described in this subsection.

Please Contact the State of New Hampshire Division of Personnel for complete information about continuation of group coverage under COBRA (federal) regulations. The following is an outline of your COBRA rights and responsibilities.

Continuation of Coverage under “COBRA” - The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a continuation law that applies only if the State of New Hampshire had an average of 20 or more benefit-eligible employees during the year. If you have any questions about COBRA continuation, contact the State of New Hampshire, Division of Personnel right away. The following is only an outline of your COBRA rights and responsibilities.

If your coverage in the State of New Hampshire’s retiree health care plan is terminated, you and your covered dependants may continue your health care Benefits for as long as 18 months.

Any qualified beneficiary may continue COBRA coverage for a period of 18 to 29 months if:

- The Social Security Administration determines at any time during the first 60 days of COBRA continuation that the beneficiary is disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and
- The qualified beneficiary provides notice and certification of disability status within 60 days of the date of determination and *before* the end of the initial 18 month period of COBRA continuation. (Medicare begins coverage for the disabled at 29 months.)

During a period of COBRA continuation, no disabled family members who are covered under the same Benefit Booklet as the disabled Member are also entitled to the 29 month disability extension.

If coverage ends because of your death, your covered dependants may continue group coverage for as long as 36 months. Your covered spouse may continue group coverage for as long as 36 months if coverage would otherwise terminate by divorce or legal separation or because you become entitled to Medicare Benefits. Your dependant children may continue group coverage for as long as 36 months if coverage would otherwise cease because they fail to meet the Anthem definition of dependant child.

A child who is born to the covered employee during a period of COBRA continuation is a qualified beneficiary. A child who is placed for adoption with the covered employee during a period of COBRA continuation is a qualified beneficiary. **You must add your newborn or adopted child to your COBRA continuation coverage by contacting the State of New Hampshire’s COBRA Administrator at 1-866-800-2272.**

If a continuing beneficiary becomes entitled to Medicare Benefits, then a qualified dependant beneficiary (other than the Medicare beneficiary) is entitled to continuation coverage for no more than a total of 36 months. These Benefits terminate if:

- A continuing beneficiary fails to pay a required premium on time, or
- The employer or insurer terminates all Benefits under its employee welfare benefit plan for all employees, or
- A continuing beneficiary becomes covered under another group health plan or entitled to Medicare benefits after he or she elects COBRA. Entitlement to Medicare means being enrolled in Medicare Part A or B or in a Medicare Select or Medicare+Choice program. Please note: If a continuing beneficiary becomes enrolled in another group health care plan, coverage may continue only if the new group health plan contains preexisting condition exclusions or limitations and may continue only until such limitations cease.

You **must notify** the Division of Personnel within 60 days of the date of your divorce or legal separation and within 60 days of the date your enrolled dependant(s) no longer meet the definition of a dependant. The State of New Hampshire must notify qualified beneficiaries of their rights to continue coverage within 14 business days.

You or an eligible family Member must decide to continue coverage within 60 days of the date your coverage would otherwise end or the date the State of New Hampshire notifies you of this right, whichever is later. You must pay the total premium appropriate for the coverage you choose to continue. The premium you pay cannot be more than 102 percent of the premium charged for employees with similar coverage and it must be paid to the State of New Hampshire within 30 days of the date due, except that the initial premium payment must be made within 45 days after the initial election for continuation of coverage or your continuation rights will be forfeited.

Section 14: Definitions

This Section defines some of the capitalized words and phrases found in this Benefit Booklet:

Adverse Determination means a decision by Anthem (or by a designated clinical review entity of Anthem), that a scheduled or emergency admission, continued stay, availability of care, or other health care service has been reviewed and does not meet Anthem's definition of Medical Necessity, appropriateness, health care setting, level of care or effectiveness. Therefore, Benefits are denied, reduced or terminated by Anthem.

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

Anthem Participating Birthing Center means a Birthing Center that has a written agreement directly with Anthem to provide Covered Services to Members.

Anthem Participating Diabetes Education Provider means a certified, registered or licensed health care expert in diabetes management who has a written agreement directly with Anthem to furnish diabetes counseling and diabetes education to Members.

Anthem Participating Nutrition Counselor means a registered or licensed dietitian practicing independently or as part of a physician practice or hospital clinic and who has a written agreement directly with Anthem to provide nutrition counseling to Members.

Anthem Participating Provider means any Designated Provider that has a written payment agreement with Anthem or with its Local Plan to provide Covered Services to Members.

Behavioral Health Care means Covered Services provided to treat Mental Disorders and Substance Abuse Conditions as defined in Section 7, V.

Benefit Booklet (or Booklet) means the document which describes the terms and conditions under this health plan. The Benefit Booklet includes this document and any endorsements and/or riders that amend this document.

Benefits means reimbursement or payments available for Covered Services, as described in this Benefit Booklet.

Birthing Center means an Outpatient facility operating in compliance with all applicable state licensing and regulatory requirements for Birthing Centers. The primary function of a Birthing Center is to provide Outpatient facility services for prenatal care, delivery of a baby and postpartum care for a mother and her newborn. A Birthing Center must have a written agreement directly with Anthem or with another Blue Cross and Blue Shield plan to provide Covered Services to Members. Otherwise, no Benefits are available for services furnished by a Birthing Center.

BlueCard Provider means a Designated Provider located outside New Hampshire that is not an Anthem Participating Provider, but has a written payment agreement with the local Blue Cross and Blue Shield plan.

Calendar Year means a period of time that starts on January 1 and ends on December 31 of any given year.

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

Contracting Provider means a Designated Provider that has a written agreement with Anthem to provide certain Covered Services to Members. A Contracting Provider is not an Anthem Participating Provider.

Convenience Services Please see Section 8, II “Exclusions” for a definition of Convenience Services.

Covered Service means the services, products, supplies or treatment as described as being eligible for Benefits in this Benefit Booklet. To be a Covered Service, the service, products, supply or treatment must be:

- Medically Necessary or otherwise specifically described as a Covered Service under this Benefit Booklet, and
- Within the scope of the license of the Designated Provider performing the service, and
- Rendered while coverage under this Benefit Booklet is in force, and
- Not Experimental or Investigational or otherwise excluded or limited under the terms of this Benefit Booklet.

The plan rules stated in this Benefit Booklet and in any amendment to this Benefit Booklet, must be met. Otherwise, a service may not be a Covered Service. Plan rules include, but are not limited to, rules such as those pertaining to services furnished by Anthem Participating Providers and requirements about approval from Anthem.

Designated Provider means the following health care providers, each being duly licensed or certified as required by law in the state which regulates their licensure and practice and each acting within the scope of the applicable license or certification: Short Term General Hospitals, Skilled Nursing and Physical Rehabilitation Facilities, facilities for laboratory and x-ray tests and screenings, individuals licensed and certified to interpret laboratory and x-ray tests and screenings, ambulatory surgical centers that have a written payment agreement with Anthem or the Blue Cross and Blue Shield plan where the center is located, hemodialysis centers, home dialysis providers and birthing centers that have a written payment agreement with Anthem or the Blue Cross and Blue Shield plan where the birthing center is located, and cardiac rehabilitation programs. Physicians include Doctors of Medicine (MDs) and Advanced Registered Nurse Practitioners (ARNPs) acting within the scope of their licenses. Designated Providers also include physician assistants, nurses and nurse-anesthetists. Home health, hospice and visiting nurse association providers and their certified staff members are also Designated Providers. Infusion therapy providers, licensed durable medical equipment, medical supply or prosthetic providers, licensed ambulance transportation providers, physical, occupational and speech therapists, doctors of osteopathy and doctors of podiatry are Designated Providers. Audiologists, optometrists, nutrition counselors, diabetes education providers, Eligible Behavioral Health Providers, chiropractors, dentists oral surgeons and New Hampshire Certified Midwives (NHCMs) are Designated Providers only to the extent of coverage stated in this Booklet. Except as determined by Anthem, no other provider is a Designated Provider. Practitioners such as acupuncturists, electrologists, doctors of naturopathic medicine and any provider of alternative or complementary medicine are not Designated Providers. School infirmaries are not Designated Providers. Except as specified in Section 7 of this Benefit Booklet, as required by law or by exception at Anthem’s discretion, Benefits are available only when Covered Services are:

- Furnished by a physician, or
- Ordered by a physician and furnished by a Designated Provider.

Developmental Disabilities means chronic mental or physical impairments that occur at an early age, are likely to continue indefinitely, result in substantial functional limitations and require special care and services of lifelong or extended duration. Such disabilities include, but are not limited to, abnormalities of the neurological and musculoskeletal systems due to congenital chromosomal anomalies or perinatal disorders, any of which may cause mental retardation or delays in mental development as well as abnormalities or delays in motor functioning and development.

Home Health Agency means a state authorized and licensed agency or organization that provides nursing and therapeutic care in the home of the Member. It must maintain permanent records of services provided to its patients, employ a full-time administrator and have at least one Registered Nurse (R.N.) either on the staff or available to it.

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

Local Plan means the Blue Cross and Blue Shield Plan in the geographic area outside the Service Area where you receive Covered Services. The Local Plan has standard payment agreements with BlueCard Providers.

Maximum Allowable Benefit (MAB) means the dollar amount available for a specific Covered Service. Anthem determines the MAB for approved Covered Services that you receive in New Hampshire. Anthem also determines the MAB for Covered Services that you receive from a nonBlueCard Provider outside New Hampshire. The local Blue Cross and Blue Shield plan determines the MAB for Covered Services furnished by BlueCard Provider. Anthem Participating Providers and BlueCard Providers accept the MAB as payment in full.

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

Medically Necessary or "Medical Necessity" means health care services or products provided to an enrollee for the purposes of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the enrollee or the Provider.

Please note: The fact that a Designated Provider or other health practitioner orders, prescribes, recommends or furnishes health care services or products will not cause the intervention to be automatically considered Medically Necessary. Anthem may consult the Medical Director and/or independent medical specialists, peer review committees, or other health care professionals qualified to make a recommendation regarding the Medical Necessity of any service or product prescribed for a Member.

You have the right to appeal Benefit determinations made by Anthem or its delegated entities, including Adverse Determinations regarding medical necessity. Please refer to the appeal process in Section 11 of this Benefit Booklet for complete information.

Please review plan rules stated in Sections 1 through 6 in this Benefit Booklet. Benefits may be denied if you fail to follow plan rules, whether or not your service meets Anthem’s definition of “Medically Necessary.” Plan rules include, but are not limited to, rules such as those pertaining to services furnished by Anthem Participating Providers and requirements about Precertification from Anthem.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Medicare Assignment means an arrangement whereby a provider or supplier agrees to accept the *Medicare approved amount* as the charge for the service or item covered under Part B. Medicare will pay its benefits directly to the provider.

Member means a Subscriber covered under this Benefit Booklet.

NonBlueCard Provider means a Designated Provider outside New Hampshire that does not have a standard written payment agreement with the Local Blue Cross and Blue Shield Plan.

Nonparticipating Provider means any Designated Provider that is not an Anthem Participating Provider. Providers who have not contracted or affiliated with Anthem’s designated Subcontractor(s) for the services that are Covered Services under this Benefit Booklet are also considered Nonparticipating Providers.

Outpatient means any care received in a health care setting other than an Inpatient setting. “Inpatient” is defined above.

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

Plan means this Medcomp Three health care plan, as described in this Benefit Booklet.

Post-Service Claims are claims for services that you have received and which do not meet the definition of “Pre-Service Claim,” stated below. Post-Service Claims do not include requests for reimbursement made by providers according to the terms of their agreement with Anthem unless Anthem reduces or denies Benefits.

Precertification or Precertify means Anthem’s written confirmation that a service is Medically Necessary. Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of the Benefit Booklet that is in effect on the date that you receive Covered Services.

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

Prior Approval. Prior Approval is a process used by Anthem to review proposed services at the request of a Member’s physician. The purpose of the review is to determine in advance that a proposed service is a Covered Service that meets Anthem’s definition of Medical Necessity, as stated above in this Section. Prior Approval differs from Precertification because it is a voluntary request for Anthem’s review. Prior Approval is not a step that either you or your provider are required to take under the terms of this Benefit Booklet.

Retiree means an individual who is retired from active employment with the State of New Hampshire and who the State of New Hampshire determines is eligible to continue coverage under this Benefit Booklet pursuant to NH law and/or the State of New Hampshire rules governing eligibility for Retiree coverage.

Service Area means the State of New Hampshire. The Service Area also includes those cities and towns of Maine, Massachusetts and Vermont whose borders directly adjoin the New Hampshire border whose Designated Providers have written payment agreements directly with Anthem.

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

Skilled Nursing Facility means an institution which is, pursuant to law, in compliance with all applicable state licensing and regulatory requirements and which provides room and board accommodations and 24-hour-a-day nursing care under the supervision of a Physician and/or Registered Nurse (R.N.) while maintaining permanent medical history records.

Subcontractor. Anthem may subcontract particular services to organizations or entities called Subcontractors having specialized expertise in certain areas. This may include but is not limited to mental health and/or substance abuse care. Such Subcontractors or subcontracted organizations or entities may make Benefit determinations and/or perform administrative, claims paying, or customer service duties on behalf of Anthem.

Subscriber means you, the State of New Hampshire Retiree, to whom this Benefit Booklet is issued.

Urgent Care Claim means any request for Precertification or preauthorization submitted as required under this Benefit Booklet, for care or treatment with respect to which the application of time periods for making non-urgent Pre-Service Claim determinations:

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

You and Your. Unless specifically stated otherwise, the words “you” and “your” refer to you, the person to whom this Benefit Booklet is issued (the Subscriber).

