BlueChoice® New England (POS) Benefit Booklet

The State of New Hampshire Health Plan for Active Employees

What You Need to Know about Your Managed Health Care Plan

This BlueChoice New England Benefit Booklet describes The State of New Hampshire's Point-of-Service (POS) Managed Health Care Plan

Anthem's toll-free telephone number is 1-800-933-8415
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3000 Goffs Falls Road, Manchester, New Hampshire 03111-0001

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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. Visit Anthem's website at www.anthem.com or 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

Douglas J. Wenners
President and General Manager
New Hampshire

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

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BlueChoice® New England (POS)
Cost Sharing Schedule

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

Cost Sharing Summary	YOUR COST	
	Network Benefits	**Out-of-Network Benefits** **Benefits are limited to the Maximum Allowable Benefit ***
Visit Copayment Applies each time you visit your PCP or Network Provider	$10 per visit	subject to the standard deductible and coinsurance amounts listed below
Specialty Visit Copayment Applies each time you visit certain Specialists**	$20 per visit	
Walk-In Center Copayment Applies each time you visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of an illness of injury.	$20 per visit	
Emergency Care/Urgent Care Copayment	$50 per visit	$50 per visit
Standard Deductible	not applicable	$150 per Member, per calendar year $450 per family, per calendar year
Standard Coinsurance		20%
Coinsurance Maximum		$1,350 per Member, per calendar year $2,550 per family, per calendar year
Durable Medical Equipment, Medical Supplies and Prosthetics **Deductible** **Coinsurance** **Maximum Benefit**	 not applicable not applicable not applicable	 $100 per Member, per calendar year 20% not applicable
Out-of-Pocket Maximum Please see Section 2 of your Benefit booklet for details.	$500 per Member per calendar year $1,000 per family per calendar year	$1,500 per Member, per calendar year $3,000 per family, per calendar year

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, you may be responsible for paying the difference between the MAB and charge. Please see Section 2 of your Benefit Booklet for details.

**There are certain in-network services that are not subject to the $20 Specialty Copayment: allergy treatment/injections, short-term rehabilitative therapy (cardiac, physical, occupational, or speech therapy), chiropractic, outpatient mental health and substance abuse treatment, and routine vision care. These services would be subject to a $10 per visit copayment.

Coverage Outline	Your Cost	
Medical/Surgical Care		
I. Inpatient Services	**Network Benefits**	**Out-of-Network Benefits ***
in a Short Term General Hospital (facility charges for medical, surgical and maternity admissions)	You pay $0	$150 Deductible, per Member per calendar year, 20% Coinsurance, up to $1,350 per Member per calendar year $450 Deductible, per family per calendar year 20% Coinsurance, up to $2,550 per family per calendar year
in a Skilled Nursing Facility or Physical Rehabilitation Facility (facility charges) up to a combined total of 30 Inpatient days per Member, 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 *For Skilled Nursing or Physical Rehabilitation Facility admissions: limited to the number of Inpatient days stated above.*		
II. Outpatient Services		
Preventive Care		
immunizations for babies, children and adults (including travel and rabies immunizations) mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening	You pay $0	You pay any balances after Anthem pays 100% of the Maximum Allowable Benefit
routine physical exams for babies, children and adults (including one annual gynecological exam) † preventive vision and hearing screening furnished as part of a routine physical exam furnished by a physician (usually your PCP) *limited to one screening each year for Members 18 years old or younger* † nutrition counseling - limited to three visits per Member, per calendar year † (*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)*		$150 Deductible, per Member per calendar year, 20% Coinsurance, up to $1,350 per Member per calendar year $450 Deductible, per family per calendar year 20% Coinsurance, up to $2,550 per family per calendar year
routine vision exams - one exam per Member, per calendar year for Members 18 years old or younger, one exam every two years for Members 19 or older †	$10 Visit Copayment	
diabetes management program	You pay $0	

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, you may be responsible for paying the difference between the MAB and charge. Please see Section 2 of your Benefit Booklet for details.

† Any combination of Network Benefits and Out-of-Network counts toward this limit.

Coverage Outline	Your Cost	
	Network Benefits	**Out-of-Network Benefits***
Medical/Surgical Care in a Physician's Office (in addition to the Preventive Care above)		
medical exams, consultations, family planning visits, office surgery and anesthesia, medical treatments, telemedicine visits	$10 Visit Copayment or $20 Specialty Visit Copayment	$150 Deductible, per Member per calendar year, 20% Coinsurance, up to $1,350 per Member per calendar year $450 Deductible, per family per calendar year 20% Coinsurance, up to $2,550 per family per calendar year
medical exams, consultations, family planning visits, office surgery and anesthesia, medical treatments and telemedicine visits furnished by a Network Provider in a Network Walk-in Center	$20 Specialty Visit Copayment	
allergy treatment/injections	$10 Visit Copayment	
allergy serum (administered in a physician's office) 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 your Benefit Booklet for information about total maternity care.	You pay $0	
Also, see III, "Outpatient Physical Rehabilitation Services" (below)		
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.)		
medical exams and consultations by a physician and telemedicine visits	$10 Visit Copayment or $20 Specialty Visit Copayment	$150 Deductible, per Member per calendar year, 20% Coinsurance, up to $1,350 per Member per calendar year $450 Deductible, per family per calendar year 20% Coinsurance, up to $2,550 per family per calendar year
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)	You pay $0	
Also, see III, "Outpatient Physical Rehabilitation Services" (below)		
Emergency Care and Urgent Care - Emergency Room Visits and Urgent Care Facility Visits		
use of a hospital emergency room or an Urgent Care Facility, including an Urgent Care Facility located in the Outpatient department of a hospital *The Copayment is waived if you are admitted to a hospital as a bed patient directly from an emergency or urgent care facility*	$50 Emergency Care or Urgent Care Copayment each visit	$50 Emergency Care or Urgent Care Copayment each visit
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.	You pay $0	

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, you may be responsible for paying the difference between the MAB and charge. Please see Section 2 of your Benefit Booklet for details.

Coverage Outline	Your Cost	
	Network Benefits	**Out-of-Network Benefits ***
III. Outpatient Physical Rehabilitation Services		
Physical Therapy, Occupational Therapy and Speech Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation and Cognitive Rehabilitation **Network Benefits**: unlimited Medically Necessary visits **Out-of-Network Benefits**: up to a maximum of $3,000 per Member, per calendar year for all therapies combined	$10 Visit Copayment	$150 Deductible, per Member per calendar year, 20% Coinsurance, up to $1,350 per Member per calendar year $450 Deductible, per family per calendar year 20% Coinsurance, up to $2,550 per family per calendar year
Chiropractic Care • *limited to 20 office visits per Member, per calendar year†* • *laboratory and x-ray tests furnished by a chiropractor*	$10 Visit Copayment You pay $0	$150 Deductible, per Member per calendar year, 20% Coinsurance, up to $1,350 per Member per calendar year $450 Deductible, per family per calendar year 20% Coinsurance, up to $2,550 per family per calendar year
Early Intervention Services Limited *to $3,200 per Member per calendar year and $9,600 per Member per lifetime †*	$10 Visit Copayment	
IV. Home Care (in addition to the Preventive Care listed in subsection II above)		
physician services, medical exams, consultations, office surgery and anesthesia, medical treatments, telemedicine visits	$10 Visit Copayment or $20 Specialty Visit Copayment	$150 Deductible, per Member per calendar year, 20% Coinsurance, up to $1,350 per Member per calendar year $450 Deductible, per family per calendar year 20% Coinsurance, up to $2,550 per family per calendar year
allergy treatment/injections	$10 Visit Copayment	
allergy serum (administered in your home by a physician)	You pay $0	
Home Health Agency services		
Hospice		
Infusion Therapy		
Durable Medical Equipment, Medical Supplies and Prosthetics	You pay $0	$100 DME Deductible, per Member, per calendar year, 20% coinsurance

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, you may be responsible for paying the difference between the MAB and charge. Please see Section 2 of your Benefit Booklet for details.

† Any combination of Network Benefits and Out-of-Network counts toward this limit.

Coverage Outline	Your Cost	
V. Behavioral Health Care		
To receive **Network Benefits**, you must receive Covered Services from a Network Behavioral Health Provider. **Out-of-Network Benefits** are available when your Covered Services are furnished by any Eligible Behavioral Health Provider, as approved in advance by Anthem. Please see Section 7 in this Benefit Booklet for details.		
Outpatient/office visits ***telemedicine visits, group therapy and Intensive Outpatient Treatment Programs (IOP)***	**Network Benefits**	**Out-of-Network Benefits ***
Mental Health visits-*Unlimited Medically Necessary visits* • Individual therapy • Group therapy • Intensive Outpatient Treatment Programs (IOP)	$10 Visit Copayment	$150 Deductible, per Member per calendar year, 20% Coinsurance, up to $1,350 per Member per calendar year $450 Deductible, per family per calendar year, 20% Coinsurance, up to $2,550 per family per calendar year
Substance Abuse visits – *Unlimited Medically Necessary visits* • Individual therapy • Group therapy • Intensive Outpatient Treatment Programs (IOP)		
Inpatient Services		
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-*Unlimited Medically Necessary days* • Inpatient • Partial Hospitalization Program (PHP)	You pay $0	$150 Deductible, per Member per calendar year, 20% Coinsurance, up to $1,350 per Member per calendar year $450 Deductible, per family per calendar year, 20% Coinsurance, up to $2,550 per family per calendar year
Substance Abuse Conditions- *Unlimited Medically Necessary days* • 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, as approved by Anthem's Precertification	You pay $0	
VI. Health Education Reimbursement – Please see Section 7, VI, I in your Benefit booklet for complete information.		
Approved community health education classes are limited to $150 per family per calendar year	You pay amounts that exceed the $150 reimbursement	

* Benefits are limited to the Maximum Allowable Benefit (MAB). Under Out-of-Network Benefits, you may be responsible for paying the difference between the MAB and charge. Please see Section 2 of your Benefit Booklet for details.

SECTION 1: OVERVIEW – HOW YOUR PLAN WORKS

Please see Section 14 for definitions of specially capitalized words.

I. About this Benefit Booklet

This is your Benefit Booklet. It describes a partnership between you, your physician, the State of New Hampshire (your employer) and Anthem. You are entitled to the Benefits described in this Benefit Booklet. Certain rights and responsibilities are also described in this Benefit Booklet.

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

There Are Two Levels of Benefits under this Managed Health Care Plan: Network Benefits and Out-of-Network Benefits. Your out-of-pocket costs are less when you chose Network Benefits. Please read Sections 3 and 4 for details about your choice of Benefit levels.

II. Your Primary Care Provider (PCP)

In this Benefit Booklet, your Primary Care Provider is called your PCP. It is recommended that each Member selects a PCP from one of the plan Designated Networks at enrollment time. Your PCP is a physician who becomes familiar with your medical history, may furnish your primary care and coordinates other health care services. PCPs include internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), and pediatricians. Whenever possible, you should talk to your PCP *before* you receive health care services. If you need specialized care, your PCP may assist in coordinating your care by working with the hospitals, specialists and suppliers in the Network.

To select your PCP, use the applicable Local Plan's provider directory, which Anthem makes available at enrollment time. For example, to select a New Hampshire PCP, use the New Hampshire directory. To select a Massachusetts PCP, use the Massachusetts directory. Or, call Customer Service for assistance. Anthem's toll free number is listed on your identification card.

Only Out-of-Network Benefits will be available if your care is not provided by your PCP or Network Provider. Please read Sections 3 and 4 for more information about your Benefit options.

III. Precertification

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

In most cases, Anthem works with you and your provider to discuss proposed services *before* you receive certain Covered Services. This written approval is called "Precertification." Precertification is Anthem's written agreement that your care is Medically Necessary. Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Benefit Booklet, including but not limited to, Copayments, Deductibles, Coinsurance, limitations and exclusions. Contact Anthem's Customer Service Center to be sure that Precertification has been obtained.

For **Network Services** -With few exceptions, your PCP will refer you to a Network Provider for your specialized care. Your PCP or Network Provider will obtain any required Precertification from Anthem or from the Local Plan for Network Services.

For **Out-of-Network Services** - You, not your provider, are responsible for making sure Precertification is obtained from Anthem before you receive certain services. See Section 4, "Out-of-Network Services," for more information about services that require Precertification. When you contact Anthem for Precertification, Anthem will obtain information from you and from your physician in order to review the Medical Necessity of the service. If Anthem determines that your care is Medically Necessary, Anthem will notify you, your physician and the hospital or facility that the service is approved. If Anthem determines that the care is not Medically Necessary, Anthem will notify you and your physician.

If you do not obtain Precertification from Anthem as required, and Anthem later determines that your care was not Medically Necessary, then no Benefits will be available and you will be responsible for the full cost of your care.

Please see Section 5 for more information about the Precertification process.

IV. The Network

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

Network Providers in New Hampshire are physicians, including Primary Care Providers (internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), and pediatricians) and specialists, hospitals and other health care providers and facilities that have a network payment agreement directly with Anthem Health Plans of New Hampshire, Inc., (Anthem) to provide Covered Services to Members. New Hampshire Network Providers are listed in the New Hampshire 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 New Hampshire Network Providers, please go to Anthem's website, www.anthem.com. Or, you may contact Customer Service for assistance. The toll-free telephone number is on your identification card.*

Network Providers Outside New Hampshire are physicians, including Primary Care Providers (internists, family practitioners, general practitioners, Advanced Practice Registered Nurses (APRN), and pediatricians), and specialists, hospitals and other health care providers and facilities *outside New Hampshire* that have a written payment agreement directly with one of the affiliated New England Local Plans. Network Providers are listed in each Local Plan's Network Directory, which is provided to Members by Anthem. Printed directories are updated periodically. Therefore, your directory book may not always be current at the time you need to arrange for Covered Services. Contact Customer Service for assistance in locating Network Providers in parts of the Service Area outside New Hampshire.

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

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

Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Subcontractors may include but are not limited to prescription drugs and/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 a Network Provider or any other provider and the decision to receive or decline to receive health care services is the sole responsibility of the Member. Contracting arrangements between Network Providers and Anthem or between Network Providers and one of the Local Plans should not, in any case, be understood as a guarantee or warranty of the professional services of any provider or the availability of a particular provider.

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

V. 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 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.

VI. 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, Network 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 an Out-of-Network Provider, you are responsible for paying the full cost of services that are not Medically Necessary.

Please note: 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 subject to a limitation or exclusion stated in this Benefit Booklet. These limitations apply even if a service meets Anthem's definition of Medical Necessity.

SECTION 2: COST SHARING TERMS

Please see Section 14 for definitions of specially capitalized words.

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

I. Copayments

Copayments are fixed dollar amounts that you pay each time you receive certain Covered Services.

A **Visit Copayment** applies to Outpatient visits for medical/surgical care and Behavioral Health Care. Copayment amounts may vary according to the type of provider you visit. For example, the Copayment for a visit to your PCP may be less than the Copayment for a visit to a specialist

The **Walk-In Center Copayment** applies each time you visit a Network Provider at a Network Walk-In Center for diagnosis, care and treatment of illness or injury.

An **Emergency Care/Urgent Care Copayment** applies each time you visit the emergency room at a hospital for Emergency Care. The Copayment applies each time you visit an Urgent Care Facility for urgent care, including visits to an Urgent Care Facility located in the Outpatient department of a hospital. This Copayment is waived if you are admitted to the hospital as a bed patient directly from the emergency room or Urgent Care Facility.

II. Deductible (Out-of-Network Benefits)

A Deductible is a fixed dollar amount that you pay for each Member's Covered Services each calendar year before Benefits are available for payment under this Benefit Booklet.

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

A separate Deductible applies to durable medical equipment, medical supplies and prosthetics, as described in Section 7, IV. The separate Deductible is shown on your Cost Sharing Schedule. This Deductible does not count toward meeting any other Deductible amounts and does not apply toward the Out-of-Pocket Maximum shown on your Cost Sharing Schedule.

III. Coinsurance (Out-of-Network Benefits)

After any applicable Deductible is met, Anthem pays a percentage of the cost of certain Covered Services. You also pay a percentage. The percentage that you pay is called "Coinsurance." Coinsurance applies to Covered Services as shown on your Cost Sharing Schedule.

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

A separate Coinsurance applies to durable medical equipment, medical supplies and prosthetics, as described in Section 7, IV. The separate Coinsurance amount is shown on your Cost Sharing Schedule. This Coinsurance does not count toward meeting any other Coinsurance limit and does not apply toward the Out-of-Pocket Maximum shown on your Cost Sharing Schedule.

IV. Deductible and Coinsurance Maximums (Out-of-Network Benefits)

The following cost sharing limits apply, as shown on your Cost Sharing Schedule:

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

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

C. The Out-of-Pocket Maximum applies to Out-of-Network Benefits and is equal to the Deductibles plus the Coinsurance requirements combined.

D. Under Out-of-Network Benefits, a separate Deductible and Coinsurance apply to durable medical equipment, medical supplies and prosthetics covered under Section 7, IV, E. These amounts are shown on your Cost Sharing Schedule and do not count toward meeting any other Deductible or Coinsurance maximums or the Out-of-Pocket Limit.

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

V. Other Out-of-Pocket Costs

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

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

B. Amounts That Exceed the Maximum Allowable Benefit. Benefits under this plan are limited to the Maximum Allowable Benefit. "Maximum Allowable Benefit" means the dollar amount available for a specific Covered Service. The Maximum Allowable Benefit is determined as stated in Section 14. 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.

Network 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 an Out-of-Network or a NonBlueCard Provider.

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 PCP or other Designated Provider prescribes, orders or furnishes the service and even if the service meets Anthem's definition of Medical Necessity.

SECTION 3: NETWORK BENEFITS

Please see Section 14 for definitions of specially capitalized words.

I. Network Services

You have the freedom to seek Covered Services from any Network Provider in any Designated Network. You do not need a Referral from your PCP in order to access Network Benefits for Covered Services described in this Benefit Booklet, provided your care is furnished by a Network Provider.

Please see Section 1, IV, "The Network" for more information about the Designated Networks shared by affiliated Blue Cross and Blue Shield plans.

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

Please see III, below for information about the referral exception under this health care plan.

II. Selecting a PCP

It is recommended that each Member selects a PCP from one of the Designated Networks. Even if you choose to seek Network Services from a provider who is not your PCP, you are encouraged to select a PCP in one of the Designated Networks. The choice of PCP should be made at enrollment time. Different family members may have different health care needs. Therefore, each Member may select a different PCP. For example, you may choose a general practitioner PCP who is near your workplace. But for your child, you may choose a pediatrician PCP who is near your home. Family members may select PCPs in different Designated Networks. Indicate each family Member's PCP at enrollment time.

Anthem provides directories that list PCP and other Network Providers in each Designated Network. Printed directories are updated periodically. Therefore, your directory book may not always be current at the time you need to select a PCP or locate another Network Provider. For the most up-to-date information about **New Hampshire** Network Providers, please visit Anthem's website, www.anthem.com. Or, you may contact Customer Service for assistance. For the most up-to-date information about Network Providers located **outside New Hampshire**, contact Customer Service for assistance. Anthem's toll-free Customer Service telephone number is on your identification card.

PCP Selection for Newborns – It is also recommended that you choose your newborn's PCP before your due date. Add your child to your membership as soon as possible after your baby is born by completing the enrollment process. Indicate your selection of the baby's PCP when you enroll him or her.

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

III. Plan Approval for Specialized Care

Anthem or the Local Plan must approve certain Covered Services *before* you receive them. This approval is called "Precertification." Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of the Benefit Booklet in effect on the date you receive the Covered Services.

For **Network Services** - With few exceptions, your PCP will refer you to a Network Provider for your specialized care. Your PCP or Network Provider will obtain any required Precertification from Anthem or from the Local Plan for Network Services. To receive Network Benefits for Covered Services furnished by an Out-of-Network Provider, a Referral exception and Precertification is required. See IV below.

IV. Referral Exceptions for Out of Network Services

- **Out-of-Network Services** – In limited instances, your PCP and Anthem may determine that your care cannot be furnished by a Network Provider and that it is Medically Necessary for you to receive care from an Out-of-Network Provider at a Network Benefit level. Your PCP will write a Referral and obtain Precertification from Anthem or the Local Plan before you receive Out-of-Network Services. Please contact your PCP and/or Anthem to be sure that Precertification was obtained.

  If Anthem notifies you that Out-of-Network Services are not approved for Network Benefits, and you decide to receive the services, only Out-of-Network Benefits will be available for Medically Necessary services. No Benefits will be Precertified or available for elective Inpatient or Outpatient care that can be safely delayed until you return to the Service Area or for care that a reasonable person would anticipate before leaving the Service Area. School infirmary facility or infirmary room charges are not covered under any portion of this Benefit Booklet. 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.

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

  Note: Covered emergency ambulance Services are eligible for Network Benefits, regardless of the location of the service. Out-of-Network Benefits are not applicable.

Please see Section 4, II for important information about Precertification rules that apply to certain Out-of-Network Services.

SECTION 4: OUT-OF-NETWORK BENEFITS

Please see Section 14 for definitions of specially capitalized words.

Significant Benefits are available under your Out-of-Network Benefits option, as shown on your Cost Sharing Schedule. Out-of-Network Benefits apply when you receive Covered Services from a provider that is not your PCP or Network Provider.

I. Out-of-Network Benefit Option

You have the freedom to seek Medically Necessary Covered Services from an Out-of-Network Provider. Significant Benefits are available under this option, but your share of the cost is higher. You pay the Out-of-Network Benefits Deductible and/or Coinsurance amounts for Covered Services. Most often, these amounts are higher than your out-of-pocket costs under Network Benefits. Please see your Cost Sharing Schedule for details.

Benefits are limited to Anthem's Maximum Allowable Benefit. You are responsible for paying the difference between the Maximum Allowable Benefit and the provider's charge if you receive Covered Services from an Out-of-Network Provider or from a NonBlueCard Provider. Out-of-Network Providers and NonBlueCard Providers may require that you pay for your services in advance and are under no obligation to file claim forms for you. Please see Section 2 for more information about Cost Sharing requirements.

Out-of-Network Benefits are not available for certain services. No Benefits are available for care which is not Medically Necessary. You are responsible for the cost of any service which is not Medically Necessary as defined in Section 14 of this Benefit Booklet.

Please remember that you must obtain Precertification *before* you receive certain services. Benefits may be denied if non-approved services are not Medically Necessary. Anthem determines Medical Necessity according to the definition found in Section 14. **Please see Section 1, III, "Precertification" and Section 3, III "Plan Approval for Specialized Care" for more information.**

Except as stated above, Out-of-Network Copayments, Deductible, Coinsurance and plan rules apply when services are furnished by an Out-of-Network Provider. Please see Section 2 for additional information about Out-of-Network Benefits, including your responsibility for paying amounts that exceed the Maximum Allowable Benefit.

II. Precertification for Out-of-Network Services

Under Out-of-Network Benefits, you are responsible for making sure Precertification is obtained from anthem *before* you receive the services described below. Precertification is Anthem's written agreement that your care is Medically Necessary. Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of this Benefit Booklet, including, but not limited to, Copayments, Deductibles, Coinsurance, limitations, and exclusions. Contact Anthem's Customer Service Center to be sure that Precertification has been obtained.

If you choose Out-of-Network Benefits, please call Anthem at 1-800-531-4450 to obtain Precertification for the following services:

A. Inpatient Admissions. You must contact Anthem for Precertification of Inpatient Admissions. **If you do not obtain Precertification as required (see below) and Anthem later determines your care is not Medically Necessary, then no Benefits will be available and you will be responsible for the full cost of your care.**

1. Non-emergency/Planned Inpatient Admission. You must obtain Precertification at least seven days *before* the day you are admitted to a hospital, Skilled Nursing Facility or Physical Rehabilitation Facility for non-emergency/planned Inpatient care. This Precertification requirement also applies if your medical physician admits you to a Short Term General Hospital for medical detoxification. A non-emergency/planned admission is any inpatient admission that is not for emergency care, as defined in Section 6. Non-emergency admissions include but are not limited to elective, scheduled or planned inpatient admissions.

2. **Notice of Maternity Admissions.** At the end of your pregnancy, you, or someone acting for you, must call Anthem at **1-800-531-4450** within 48 hours after you are admitted to the hospital (or on the next business day, whichever is later). This rule applies to admissions for vaginal deliveries and for *unscheduled* caesarian section deliveries.

   Note: For caesarian section deliveries scheduled *in advance*, follow the Precertification rules stated in 1 (above) for non-emergency/planned admissions. You must contact Anthem at **1-800-531-4450** *at least seven days before* the date of your Inpatient Admission.

3. **Emergency Admissions.** Please see Section 6 for complete information about Precertification for emergency admissions.

4. **Inpatient Admissions for Behavioral Health Care.** You must obtain Precertification from Anthem before any Inpatient Admission for Behavioral Health Care. Please see Section 7 V. for complete information.

B. Outpatient Services. You must obtain Precertification from Anthem *before* you receive the Outpatient services listed below. Please contact Anthem at **1-800-531-4450** to obtain Precertification *at least seven days before* you receive:

1. **Hospice Services.** Hospice is a home management of a terminal illness. Please see Section 7, IV, C, "Hospice" for Benefit information.

2. **Outpatient Behavioral Health Care.** You must obtain Precertification from Anthem before you receive any Outpatient Behavioral Health Care. Please see Section 7, V. for complete information.

If you do not obtain Precertification from Anthem as required, and Anthem later determines that your care was not Medically Necessary, then no Benefits will be available and you will be responsible for the full cost of your care.

SECTION 5: ABOUT MANAGED CARE

Please see Section 14 for definitions of specially capitalized words.

This is a Managed Health Care plan

This is a Managed Health Care plan. This means that when you receive certain Covered Services, Anthem (or a designated administrator) and the Local Plan 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 policies or guidelines and limitations, including, but not limited to, Anthem's medical policy and guidelines for Precertification (including Anthem's Concurrent Review process) and Care Management. 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.

"Precertification" is the process used by Anthem to review services proposed by your Network Provider 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 PCP's *Referral* and/or Anthem's Precertification do 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.

I. Your Role

You play an important role in this managed health care plan. As a Member, you should become familiar with and follow plan rules. These are described in Sections 1 through 6 of this Benefit Booklet. Knowing and following plan rules is the best way for you to enjoy all of the advantages of this coverage. For example, you must contact Anthem for Precertification before you receive certain Out-of-Network Services, as explained in Section 1 and 4. Benefits will be denied if Anthem later determines that your services were not medically necessary.

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

You can appeal any decision made by Anthem about your coverage. Please see Section 11 for information about how to inform Anthem about your suggestions or to use the appeal procedure.

II. The Role of Network Providers

Your PCP (if applicable) and other Network Providers work together to make sure that you have access to the health care services that you need. Your PCP can best oversee and coordinate your care if you choose to contact him or her before you receive health care services. You also access Network Benefits under this health care plan by contacting your PCP or Network Provider when you need care.

Most often, your PCP will provide your routine or urgent care directly. If your PCP determines that you require specialized care that falls outside his or her clinical expertise or services offered, your PCP will direct you to another Network Provider. Network Providers are expected to keep your PCP informed about their recommendations and findings and the treatment you require. Your PCP and Network Providers work together to arrange for any visits or treatments that are required in addition to those originally requested by the PCP.

Your PCP (if applicable) or Network Provider will contact Anthem or the Local Plan as appropriate for any required Precertification for your Network Services. For example, if your PCP admits you to a hospital for Inpatient care, your PCP or Network Provider will notify Anthem or the Local Plan and will provide Anthem or the Local Plan with any clinical information that may be required to review the admission. Your PCP will also contact Anthem or the appropriate Local Plan to provide the clinical information required to review a Referral to an Out-of-Network Provider. Please see Section 4 for information about Out-of-Network Benefits.

III. The Role of Anthem and the Local Plan

As the Administrator of Benefits under this health plan, Anthem's Medical Director and Medical Management Division (and the Medical Directors and Medical Services Divisions of Local Plans) play an important role in the management of your Benefits. Some examples are:

A. Referral review and Precertification - Anthem and Local Plans require Network Providers to obtain Precertification from the appropriate plan before you receive Inpatient care and before you receive certain Outpatient Services. Precertification of any Referral for Out-of-Network Services is required by Anthem and by the Local Plans. You are responsible for making sure Precertification is obtained from Anthem *before* you receive any Out-of-Network Services described in Section 4. Emergency admissions must be reported to Anthem within 48 hours so that a Precertification review of the emergency admission can be completed. If you have any questions regarding Managed Care guidelines or to determine which services require Precertification, please call the telephone number on the back of your identification card or refer to our website, www.anthem.com. "Precertification" refers to the process used by Anthem and the Local Plan to review your health care services to determine if the services are Medically Necessary and delivered in the most appropriate health care setting. Medical Necessity is defined in Section 14. Precertification does not guarantee coverage for or the payment of the service or procedure reviewed.

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

B. Prior Approval - At your provider's request, Anthem will review proposed services to determine if the service is a Covered Service that meets Anthem's definition of Medical Necessity as stated in Section 14 of this Benefit Booklet. For example, if your physician proposes Outpatient surgery that may be considered a noncovered cosmetic or dental procedure, he or she may submit clinical information for review *before* you receive the service. To make coverage determinations, Anthem refers to managed care guidelines, internal policies including, but not limited to medical policies and the terms of this Benefit Booklet. *The Prior Approval process does not satisfy Precertification requirements. If your proposed service requires Precertification, please refer to Section 1, III "Precertification", Section 3, "Network Benefits" and Section 4," Out-of-Network Benefits" for complete information.*

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

D. Determinations about Experimental/Investigational Services - Anthem makes determinations about whether or not a service is Experimental/Investigational based on the definition found in Section 8, II, "Experimental/Investigational Services." Anthem's medical policy assists in Anthem's determinations regarding Experimental/Investigational Procedures and other issues. Anthem's medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the Benefits, exclusions and limitations stated in this 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.

E. Review of New Technologies. Medical technology is constantly changing and Anthem reviews and updates medical policy periodically regarding coverage for new technologies. Anthem evaluates new medical technologies to define medical 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.

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

F. 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 1-800-531-4450. Care management program services may be appropriate for a number of circumstances, including:

- If you have an acute or chronic illness requiring frequent hospitalization, home care services or ongoing treatment, or
- 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 to you or any other Member. Anthem is given the right, at any time, to alter or cease providing Benefits for alternate care or extended Covered Services. In such cases, Anthem will notify the Member or the Member's representative in writing.

IV. Important notes about this Section

Your PCP's Referral, Anthem's Precertification or Prior Approval does not guarantee Benefits. Benefits are subject to all of the terms and conditions of the Benefit Booklet in effect on the date you receive Covered Services.

Anthem's decisions about Referrals, Precertification, Prior Approval requests, Medical Necessity, Experimental/Investigational services (as all are defined in Section 14 of this Benefit Booklet) and new technologies are not arbitrary. Anthem's Medical Director or Medical Management 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 Management Division considers published peer-review medical literature about the service, including the opinion of experts in the relevant specialty. At times, Anthem may consult with experts in the specialty. Anthem may also review determinations or recommendations of nationally recognized public and private organizations which 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.

Benefits are available for Emergency Care and urgent care. Please read this Section carefully, because important terms and limitations apply.

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.

Please note: You will have lower copayments if you to seek urgent care from your PCP, Network obstetrical/gynecological specialist or from a Network Provider at a Network Walk-In Center as an alternative to visiting a hospital emergency room or Urgent Care Facility. Please see your Cost Sharing Schedule to compare Visit Copayments, the Walk-In Center Copayment and the Emergency Care/Urgent Care Copayment. You do not need to obtain your PCP's Referral before you visit a Network Walk-In Center.

II. Emergency Care

It may not always be possible or safe to delay treatment long enough to consult with your PCP or Anthem before you seek care. In 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 you are at serious risk of harming yourself or another person.

III. Emergency Room Visits for Emergency Care

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

In order to make a determination about Emergency Care conditions, Anthem reserves the right to review medical records after you have received your services. Anthem will consider not only the outcome of your visit, but also the symptoms that caused you to seek the care.

Your share of the cost for use of the emergency room is shown on your Cost Sharing Schedule. Any Emergency Room Copayment is waived if you are admitted to the hospital as a bed patient (Inpatient) directly from the emergency room.

Please be sure to call your PCP, your Network Provider or Anthem for direction *before* you receive follow-up care after an emergency room visit.

Please note: You will have lower copayments if you to seek urgent care from your PCP, Network obstetrical/gynecological specialist or from a Network Provider at a Network Walk-In Center as an alternative to visiting a hospital emergency room or Urgent Care Facility. Please see your Cost Sharing Schedule to compare Visit Copayments, the Walk-In Center Copayment and the Emergency Care/Urgent Care Copayment. You do not need to obtain your PCP's Referral before you visit a Network Walk-In Center.

IV. Inpatient Admissions to a Hospital for Emergency Care

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

A. Medical/Surgical Admissions for Emergency Care. Benefits are available for Inpatient admissions for medical/surgical Emergency Care, provided that Inpatient care is Medically Necessary and your condition meets the definition of Emergency Care as stated in II (above) in this Section.

If it is not safe or possible to delay care until you can contact your PCP or Network Provider in advance, you (or someone acting for you) must contact your PCP, Network Provider or Anthem for Precertification **within 48 hours after you are admitted or on the next business day, whichever is later.** Please call Anthem at **1-800-531-4450** for Precertification.

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

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

Please see Section 4, II for information about Precertification for non-emergency Inpatient admissions, such as elective, planned, scheduled and maternity admissions.

B. Behavioral Health Admissions for Emergency Care. Benefits are available for Inpatient admissions for emergency Behavioral Health Care, provided that Inpatient care is Medically Necessary and your condition meets the definition of Emergency Care as stated in II (above) in this Section. If it is not safe or possible to delay care until you can contact your PCP or Network Provider in advance, you (or someone acting for you) must contact your PCP, Network Provider, or Anthem for Precertification **within 48 hours after you are admitted or on the next business day, whichever is later by calling 1-800-228-5975.**

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

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

Please see Section 7, V for information about Precertification of non-emergency Inpatient admissions for Behavioral Health Care. Scheduled Inpatient admissions must be approved *in advance* by Anthem. Benefits may be denied if you do not obtain Precertification as required and Anthem later finds that your services were not Medically Necessary.

V. Limitations

In addition to the limitations and exclusions listed in Section 8, the following limitations apply specifically to Emergency Care and Urgent care:

A. "Follow-up" care is any related Covered Service that you receive after your initial Emergency Room or Urgent Care Facility visit. To be eligible for Network Benefits for medical/surgical conditions, your follow-up care must be furnished by a Network Provider. Otherwise, only Out-of-Network Benefits are available.

For Mental Disorders or Substance Abuse Conditions, the plan rules stated in Section 7, V apply to follow-up care.

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

C. Emergency Care and Urgent Care do not include routine care. Routine care includes, but is not limited to, routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, medication checks, immunizations or other preventive care. Emergency Care and Urgent Care do not include any services related to or resulting from routine care, unless the related care is a Covered Service.

D. Emergency Care does not include elective care. Elective care includes care that can be delayed until you can contact your PCP or Network Provider or Anthem for direction. Examples of elective care include, but are not limited to: scheduled Inpatient admissions or scheduled Outpatient care. Emergency Care does not include any service related to or resulting from elective care, unless the related care is a Covered Service.

E. If you are admitted as a bed patient to an Out-of-Network Hospital for Emergency Care, Network Benefits are available only until Anthem and your PCP determines that your condition permits your transfer to a Network Hospital. The mode of transportation will be selected by Anthem and the cost of the selected transportation will be covered.

F. Care related to noncovered services. No Benefits are available for care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services, even if the care meets Anthem's definitions of Emergency Care and/or Medical Necessity.

SECTION 7: COVERED SERVICES

Please see Section 14 for definitions of specially capitalized words.

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

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

- Members are entitled to the Covered Services described in this Section. All Benefits are subject to the exclusions, conditions and limitations described in Section 8, "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 the Benefit Booklet, including, when applicable, receipt of care from your PCP, use of Network Providers, and obtaining any required Precertification.

- Benefits for Covered Services are based on the Maximum Allowable Benefit for such services. Deductible amounts are limited to the Maximum Allowable Benefit. Coinsurance is a percentage of the Maximum Allowable Benefit. No Benefits are available for amounts that exceed Anthem's Maximum Allowable Benefit.

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

- Anthem's payment for Covered Services will be limited by any applicable Cost sharing requirement or Benefit limits applicable to this plan. Such limitations are stated on your Cost Sharing Schedule, this Benefit Booklet, and in any amendment to 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. Contact your PCP, Network Provider and Anthem to be sure that Precertification has been obtained when required.

- Anthem makes determinations about Referrals, 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. *Your cost sharing amounts and important limitations are shown on the Cost Sharing Schedule.*

  - Network Benefits are available only when you receive Covered Services from your PCP or Network Provider.

- Please remember that you must call Anthem to obtain Precertification before you receive certain Covered Services. Benefits will be denied if you do not obtain Precertification as required and Anthem later determines that your services were not Medically Necessary. Please see Section 1, III, "Precertification", Section 3 "Network Benefits", Section 4, "Out-of-Network Benefits" and subsection V "Behavioral Health Care (Mental Health and Substance Abuse Care)" below in this Section for more information. Precertification rules for Emergency Care are stated in Section 6, IV "Inpatient Admissions to a Hospital for Emergency Care."

I. Inpatient Services

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

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

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, Physical Rehabilitation - Semi-private room and board, nursing and ancillary services typically provided in a Skilled Nursing, and Physical Rehabilitation Facility while you are a bed patient (Inpatient). *Benefits are limited to a certain number of Inpatient days per Member, per Calendar Year, as shown on your Cost Sharing Schedule.* Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit. 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 or the appropriate Local Plan. For Skilled Nursing and Physical Rehabilitation Facility admissions, *Benefits are limited to a certain number of Inpatient days per Member, per Calendar Year, as shown on your Cost Sharing Schedule.* Any combination of Network Benefits and Out-of-Network Benefits counts toward this limit. Custodial Care is not covered. Please see Section 8, II for a definition of Custodial Care.

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. Preventative Care. In general, the term "Preventive Care" under this Benefit Booklet refers to medical care for adults and children with no current symptoms or prior history of a medical condition associated with the care. For Members who have current symptoms or have been diagnosed with a medical condition, services associated with the symptoms or diagnoses are not Preventive Care. Some exceptions to this definition are listed below in this subsection but otherwise, services for the diagnosis or treatment of an illness, injury or medical condition are covered under other applicable sections of this 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 babies, children and adults (including travel and rabies immunizations)

2. Routine Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening

3. Routine physical exams for babies, children and adults (including one annual gynecological exam)

4. Family planning visits, such as medical exams related to family planning and genetic counseling. Outpatient/office contraceptive services are covered provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and 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 Depo-Provera) are not covered under thisBenefit Booklet. Please contact the State of New Hampshire's pharmacy benefit 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 or licensed dietitian practicing independently or as part of a physician practice or Outpatient hospital clinic. *Benefits may be 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. Routine vision exams to determine the need for vision correction. The exam must be furnished by an optometrist or ophthalmologist. *Benefits are limited, as shown on your Cost Sharing Schedule.*

   Note: preventive vision screenings are also covered for Members 18 years old and younger, provided that the screening is part of a routine physical exam. The Maximum Allowable Benefit for routine physical exams includes reimbursement for covered preventive vision screenings. No additional Benefits are available for vision screenings billed separate from the physical exam. No Benefits are available for preventive vision screenings as part of a routine physical exam for Members who are 19 years old or older.

   Please see VI, H, "Vision Services" (below this Section) for information about Benefits for treatment of eye disease or injury.

7. Preventive hearing screenings are covered for Members 18 years old and younger, provided that the screening is part of a routine physical exam. The Maximum Allowable Benefit for routine physical exams includes reimbursement for covered preventive hearing screenings. No additional Benefits are available for hearing screenings billed separate from the physical exam. No Benefits are available for preventive hearing screenings as part of a routine physical exam for Members who are 19 years old or older.

   Please see VI, B "Hearing Services" for information about services for ear disease or injury.

8. Diabetes management program. Covered Services must be ordered by a physician and furnished by a Network Diabetes Education Provider. Covered Services include:

   - Individual counseling visits

   - Group education programs and fees required to enroll in an approved group education program, and

- External insulin pump education is covered for Members whose external insulin pump has been approved by Anthem. The Network Diabetes Education Provider must be pump-certified. Please see subsection IV, E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about coverage for external insulin pumps.
  For information about diabetes education programs or Network Diabetes Education Providers, visit Anthem's website www.anthem.com or call Anthem's Customer Service Center at the telephone 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 a Network Diabetes Education Provider.

- Benefits are available for fees required to enroll in an approved group education program. 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, medication 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 A, above), 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 physician'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 is not covered under any portion of this Benefit Booklet. *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.*

   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.

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

   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.

Only Out-of-Network benefits are available for maternity care or related care when:

- The delivery occurs outside the Service Area within 30 days of the baby's due date as established by the mother's obstetrician, NHCM or ARNP, and;
- The delivery is not Precertified by Anthem before the mother leaves the Service Area. .

Please see Section 3, IV, "Plan Approval for Specialized Care" for details about the availability of Benefits and Precertification for Out-of-Network Services.

Please see VI, C (below in this section) for complete information about Benefits for "Infertility Services."

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, 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 Rehabilitation Services" (below)

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

D. Emergency Room Visits for Emergency Care. Covered Services are shown on your Cost Sharing Schedule. Please see Section 6 for important guidelines 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. The definition of Medical Necessity is stated in Section 14. If air ambulance transportation was not Medically Necessary, but ground ambulance transportation was Medically Necessary, Benefits will be provided based on the Maximum Allowable Benefit for a ground ambulance. In this case, you pay the difference between the Maximum Allowable Benefit and the air ambulance charge.

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

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

- The services would be covered if they were delivered during an in-person consultation instead of by telemedicine, and

- The services must be Medically Necessary as defined in Section 14 and

- Both the Provider and the Member must be present and participating during a telemedicine service.

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

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

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

III. Outpatient Physical Rehabilitation Services

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

A. Physical Therapy, Occupational Therapy and Speech Therapy in an office or in the outpatient department of a Short Term General Hospital or Skilled Nursing Facility.

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 affecting the voice. Such on-going services are not covered, even if ordered by your physician or supervised by skilled program personnel. In addition to the limitations and exclusions listed in Section 8 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 are limited, as shown on your Cost Sharing Schedule. Any combination of Out-of-Network physical therapy, occupational therapy, speech therapy, cognitive therapy, cardiac rehabilitation, and pulmonary rehabilitation services count toward meeting the annual Benefit limit stated on your Cost Sharing Schedule.

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: on-going or life-long exercise and education maintenance programs intended to maintain fitness or to reinforce permanent lifestyle changes. Such on-going services are not covered, even if ordered by your physician or supervised by skilled program personnel.

Benefits are limited, as shown on your Cost Sharing Schedule. Any combination of Out-of-Network physical therapy, occupational therapy, speech therapy, cognitive therapy, cardiac rehabilitation, and pulmonary rehabilitation services count toward meeting the annual Benefit limit stated on your Cost Sharing Schedule.

C. Chiropractic Care. To be eligible for Benefits, Covered Services must be furnished by a licensed chiropractor, and;

- Medically Necessary for the treatment of an illness or injury that is diagnosed or suspected by a licensed chiropractor or another provider, and
- Provided in accordance with New Hampshire law.

Otherwise, no Benefits are available for the services of a chiropractor.

Covered Services are limited to:

- Office visits for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment. *Benefits are limited as shown on your Cost Sharing Schedule,* and

- Medically Necessary diagnostic x-rays furnished by a licensed chiropractor.

Wellness care is not covered. The limitations and exclusions stated in Section 8 also apply.

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 above.

Any combination of Network and Out-of-Network Benefits count toward meeting the annual Benefit limit stated on your Cost Sharing Schedule.

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 are limited, as shown on your Cost Sharing Schedule. Any combination of Out-of-Network physical therapy, occupational therapy, speech therapy, cognitive therapy, cardiac rehabilitation, and pulmonary rehabilitation services count toward meeting the annual Benefit limit stated on your Cost Sharing Schedule.

E. Early Intervention Services. Early intervention services are covered for eligible Members from birth to the Member's third birthday. Eligible Members are those with significant functional physical or mental deficits due to a Developmental Disability. Covered Services include Medically Necessary physical, speech/language and occupational therapy, nursing care and psychological counseling.

Benefits are limited, as shown on your Cost Sharing Schedule.

F. 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 are limited, as shown on your Cost Sharing Schedule. Any combination of Out-of-Network physical therapy, occupational therapy, speech therapy, cognitive therapy, cardiac rehabilitation, and pulmonary rehabilitation services count toward meeting the annual Benefit limit stated 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:

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

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

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

4. Physical, occupational, and speech therapy. These therapy services provided by a Home Health Agency do not count toward the Out-of-Network limits stated in A, "Physical Therapy, Occupational Therapy and Speech Therapy" (above).

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

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

6. Nutrition counseling provided as part of a covered home health plan. The nutrition counselor must be a registered dietitian employed by the covered Home Health Agency. Nutrition counseling visits provided as part of a covered home health plan do not count toward any visit limits stated in section II of your Cost Sharing Schedule for Outpatient nutrition counseling.

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

- Care must be approved *in advance* by the patient's physician and by Anthem's Precertification or the appropriate Local Plan,
- 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 Precertification. Otherwise, no Benefits are available. Covered Services that may be part of the individual hospice plan are:

1. Skilled nursing visits
2. Home health aide and homemaker services
3. Physical therapy for comfort measures. These physical therapy services do not count toward the Out-of-Network limits stated in A, "Physical Therapy, Occupational Therapy and Speech Therapy" (above).
4. Social service visits
5. Durable medical equipment and medical supplies.
6. Respite care (in the home) to temporarily relieve the primary care giver from care-giving functions
7. Continuous care, which is additional respite care to support the family during the patient's final days of life
8. Bereavement services provided to the family or primary care giver following the death of the hospice patient.

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

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

E. Durable Medical Equipment, Medical Supplies, and Prosthetic Devices. Benefits are available for covered durable medical equipment (DME), medical supplies and prosthetic devices.

To be eligible for **Network Benefits**, Covered Services under this subsection must be ordered *in advance* by your physician and furnished by a Network Provider. Otherwise only Out-of-Network Benefits are available.

To be eligible for **Out-of-Network Benefits**, Covered Services must be ordered *in advance* by your physician and furnished by a licensed medical equipment, medical supplies or prosthetics provider. Otherwise no Benefits are available. Under Out-of-Network Benefits, you are responsible for paying the difference between the Maximum Allowable Benefit and the provider's charge, as explained in Section 2 of this Benefit Booklet.

Out-of-Network Services are subject to Deductible and Coinsurance for Durable Medical Equipment (DME), Medical Supplies and Prosthetics. These Deductible and Coinsurance amounts are shown on the first page of your Cost Sharing Schedule and are separate cost sharing amounts that do not count toward meeting any other Deductible or Coinsurance requirement under this Benefit Booklet. Exceptions are stated below.

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 physician to contact Anthem for prior approval *before* you purchase the pump.** Anthem will require treatment and clinical information in writing from your physician. Anthem will review the information and determine in writing whether the services are covered or excluded under this Benefit Booklet, based on the criteria stated in this Benefit Booklet. You may contact Anthem to request a copy of Anthem's internal guidelines or go to Anthem's website, 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, 8 "Diabetes Management Program" (above in this Section) for information about external insulin pump education. Implantable insulin infusion pumps are not covered.

   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.

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

   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 physician has diagnosed. Otherwise, no Benefits are available.

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

   Other covered medical supplies are:

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

     Please 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.

   The Out-of-Network DME Deductible and Coinsurance (shown on the first page of your Cost Sharing Schedule) do not apply to covered enteral formula and modified low protein food products. Benefits for modified low protein food products are limited to a total of $1,800 per Member, per Calendar Year.

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

   Coverage for external breast prostheses is limited to two prostheses per breast, per calendar year. The Maximum Allowable Benefit for breast prosthesis includes the cost of fitting for the prosthesis.

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

A **scalp hair prosthesis** is an artificial substitute for scalp hair that is made specifically for you. Benefits are available for scalp hair prostheses 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 of this Benefit Booklet, the following limitations apply specifically to medical equipment, medical supplies and prosthetic devices:

- 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 that the service meets Anthem's definition of Medical Necessity, as stated in Section 14 of this Benefit Booklet. Purchase of an electric breast pump is not covered.

- Benefits are available for custom-fitted helmets or headbands (dynamic orthotic cranioplasty) to change the shape of an infant's head only when the service is provided for moderate to severe asymmetry (nonsynostotic plagiocephaly and brachycephaly) and the condition meets the definition of a reconstructive service found in VI, "Surgery" below in this Section. To be eligible for Benefits, an infant Member must be at least three months old, but no older than 18 months. Also, the infant must have completed at least two months of cranial repositioning therapy or physical therapy with no substantial improvement. Otherwise, no Benefits are available for cranial helmets or any other device intended to change the shape of a child's head. Please contact Anthem at the toll free phone number on your identification card for a copy of Anthem's internal guidelines.

- 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 Ultraviolet 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 your PCP or treating physician 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 this subsection "Medical Supplies" (above), TENS units for incontinence, blood pressure cuffs, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for Internet sites or software, or any other media instruction or for any other educational or instructional material, technology or equipment; 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 under any portion of this Benefit Booklet. Convenience Services include, but are not limited to personal comfort items and any equipment, supply or device that is primarily for the convenience of a Member, the Member's family or a Designated Provider.

  Except as specified in this Benefit Booklet, no Benefits are available for the cost of medical equipment, supplies, prosthetics, materials or devices.

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

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

The term "Precertification" refers to Anthem's written confirmation that a service is Medically Necessary, as defined in Section 14. Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of the Benefit Booklet in effect on the date you receive Covered Services.

- **Network Services.** Benefits are available when you receive Covered Services from a Network Behavioral Health Provider. Network Behavioral Health Providers will obtain any required Precertification from Anthem.

- **Out-of-Network Services.** Benefits are available when you receive Covered Services from any Eligible Behavioral Health Provider (who is not a Network Provider). **You (not your provider) must contact Anthem for Precertification *before* you receive any Out-of-Network Services, even if you are temporarily outside the Service Area for a definite period of time (such as students, vacationers and business travel).**

Please call Anthem at 1-800-228-5975 for Precertification.

After you call, Anthem will send you a letter specifying the Precertified Covered Services. If your Behavioral Health Provider is named on the Precertification letter, you must receive Covered Services from the provider named. Otherwise, only Out-of-Network Benefits will be available. If Anthem notifies you that Out-of-Network Services at an In-Network level of Benefit exception is not approved, and you decide to receive the services, only Out-of-Network Benefits will be available and you will be responsible for paying the difference between the Maximum Allowable Benefit and the provider's charge. No Benefits will be Precertified or available for elective Inpatient or Outpatient care that can be safely delayed until you return to the Service Area or for care that a reasonable person would anticipate before leaving the Service Area. School infirmary facility or infirmary room charges are not covered under any portion of this Benefit Booklet. 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.

If you do not obtain Precertification *in advance* as required and Anthem later determines that it was not Medically Necessary for you to receive care outside the Network or that your care was not Medically Necessary, then no Benefits will be available and you will be responsible for the full cost of your care.

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

B. Covered Behavioral Health Care Services. Benefits are available for the diagnosis, crisis intervention and 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).

- **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, medication checks and psychological testing, including but not limited to Medically Necessary psychological testing for bariatric surgery candidates. Group Therapy visits are covered. Emergency room visits are not covered under this subsection. Emergency room 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 Practice Registered Nurses, and Psychologists.

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

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

- The services would be covered if they were delivered during an in-person consultation instead of by telemedicine, and

- The services must be Medically Necessary as defined in Section 14, and

- Both the Provider and the Member must be present and participating during a telemedicine services.

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

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

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

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.

Covered Services must be furnished by an Intensive Outpatient Treatment Program as defined in this Subsection, "Eligible Behavioral Health Providers" (below) for the definition of an Intensive Outpatient treatment program.

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.

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 your PCP 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 Partial Hospitalization Programs in the Network, except as stated in A (above), "Out-of-Network Benefits." 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. 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 multi-disciplinary 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 RSA 330-A: 21. 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 article. Marriage or couple's 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 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, which 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 Practice Registered Nurse - a professional who is licensed as a registered nurse in advanced practice by the State of New Hampshire or licensed in accordance with the provisions of the laws of the state in which they practice and who is certified as a clinical specialist in psychiatric and mental health nursing.

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

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

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

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

Note: Benefits are available for Precertified 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 for the services of the out-of-state provider.

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 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 and treatment 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 mental health or substance abuse 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 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),

- Except for the psychological testing covered in B “Outpatient/office visits,” and 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), and Section 7, VI, I “Community Health Education”, 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.

- 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, except as stated in Section 7, I Community Health Education,

- Psychoanalysis,

- Confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings,

- Missed appointments,

- Except as stated in B "Telephone Services," telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider,

- Inpatient care for medical detoxification extending beyond the acute detoxification phase of a Substance Abuse Condition,

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

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

- Experimental/Investigational services or nontraditional therapies such as, but not limited to crystal or aroma therapies,

- School infirmary facility or infirmary room charges are not covered under any portion of this Benefit Booklet.

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

- 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 above. 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 this 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, 4 and 5 (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 under parts I and II of your Cost Sharing Schedule.

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

   a. Surgical removal (extraction) of erupted teeth before radiation therapy for malignant disease**.** Benefits are limited to:
   - The surgeon's fee for the surgical procedure,
   - General anesthesia furnished by a licensed anesthesiologist or anesthetist 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. a. 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 under 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 for TMJ disorders 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, only Out-of-Network 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 anesthetist is covered in conjunction with a covered surgery. Medically Necessary Inpatient and Outpatient hospital care is covered in conjunction with a covered surgery, subject to all of the terms of this **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 anesthetist when it is Medically Necessary for certain Members to undergo a dental procedure under general anesthesia in a hospital facility or surgical day care facility. Members who are eligible for facility and general anesthesia Benefits are:

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

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

Except as stated in Section 7, II "preventive hearing screenings," 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 Section 7. 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 Section 7, IV, E "Durable Medical Equipment, Medical Supplies and Prosthetics."

C. Infertility Services

Benefits are available for the infertility 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 12 consecutive months, as medically documented. Anthem may waive the applicable time limits when the cause of infertility is known and medically documented. Please note that menopause in a woman is considered a natural condition and is not considered "infertility" for the purposes of determining Benefit availability under this health plan.

To be eligible for Benefits, Covered Services must be Medically Necessary, as defined in Section 14 of this Benefit Booklet, and:

- furnished by your PCP, or
- Network Obstetrician /Gynecologist.

Otherwise, only Out-of-Network Benefits are available.

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

1. **Infertility Diagnostic Services** to determine the cause of medically documented infertility. Covered Services are:

   a. Medical exams,

   b. Laboratory tests, including sperm counts and motility studies, sperm antibody tests, cervical mucus penetration tests,

   c. Surgical procedures, and

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

2. **Standard Infertility Treatment Services** are Covered Services. Standard infertility treatments include the following:

   a. Medical exams and consultations for treatment of infertility and medical treatment for prescribing and monitoring the use of fertility drugs and hormones,

   b. Male or female fertility hormones or drugs administered in a physician's office or in the Outpatient department of a hospital,

   c. Surgical procedures and anesthesia to correct medical conditions contributing to infertility,

d. Intracervical or intrauterine artificial insemination (AI) using the partner's sperm (AIH). Benefits are available for procurement and use of a partner's sperm, provided that both male and female partners are actively involved in the infertility treatment. Benefits are available for surgical procedures to retrieve sperm from an actively involved partner when surgical retrieval is Medically Necessary. For example, it may be Medically Necessary to surgically retrieve sperm when a male partner has an uncorrectable blockage anywhere along the seminal tract. No Benefits are available for procurement or surgical retrieval procedures required as a result of prior voluntary sterilization. Electroejaculation Microsurgical epididymal sperm aspiration (MESA) is covered only for actively involved partners with a congenital absence or congenital obstruction of the vas deferens.

e. Artificial insemination using donor sperm (AID) is covered only when donor services are Medically Necessary. For example, donor services may be Medically Necessary when an actively involved partner's sperm motility or quantity measures are so low that the medical expectation of successful insemination is significantly reduced.

f. Sperm washing for artificial insemination is covered.

g. Laboratory and x-ray tests (including ultrasound) and laboratory services related to covered standard infertility treatments.

3. Assisted Reproductive Technology (ART). Subject to the terms of this subsection, the following ART procedures are Covered Services:

a. in-vitro fertilization and embryo transfer (IVF-ET). Covered IVF-ET services include, but are not limited to procedures such as zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT) and natural oocyte retrieval (NORIF or NORIVF).

Only *medicated* cycles of IVF-ET procedures are covered. A complete *medicated* cycle begins when you start to take covered fertility drugs or hormones in preparation for the procedure. The cycle ends with embryo transfer. *Exception:* NORIF and NORIVF cycles are not medicated, but the cycles are covered. A NORIF or NORIVF cycle begins with oocyte retrieval and ends with embryo transfer.

Incomplete IVF-ET cycles are covered, subject to all the terms of this subsection.

Please note: when the cause of infertility cannot be explained (for example, the reproductive process of both partners appears to be normal), Anthem may require the Member to receive up to three medicated artificial insemination (AI) cycles before beginning an IVF-ET cycle. Benefits will be available for IVF-ET cycles only after Medically Necessary AI cycles are completed.

b. The following are Covered Services only when provided as part of a covered ART cycle, as described in a, (above):

- cryopreserved embryo transfer (CET),
- intracytoplasmic sperm injection (ICSI),
- intravaginal culture (IVC),
- Assisted hatching is covered only when Medically Necessary, as defined in Section 14. For example, assisted hatching may be Medically Necessary when a Member experiences two or more failed IVF-ET cycles.
- Medically Necessary harvesting of the patient's eggs. Harvest and use of donor eggs is covered only when donor services are Medically Necessary. For example, donor eggs may be Medically Necessary when adequacy of a Member's egg harvest is so low that medical expectation of a live birth result is significantly reduced.

- Procurement and use of the partner's sperm is covered for ART procedures, provided that both male and female partners are actively involved in the infertility treatment. Benefits are available for surgical procedures to retrieve sperm from an actively involved partner when surgical retrieval is Medically Necessary. For example, it may be Medically Necessary to surgically retrieve sperm when a male partner has an uncorrectable blockage anywhere along the seminal tract. No Benefits are available for procurement or surgical retrieval procedures required as a result of prior voluntary sterilization. Electroejaculation Microsurgical Epididymal Sperm Aspiration (MESA) is covered only for actively involved partners with a congenital absence or congenital obstruction of the vas deferens.

  Procurement and use of donor sperm is covered only when donor services are Medically Necessary. For example, donor sperm may be Medically Necessary when an actively involved partner's sperm motility or quantity measures are so low that the medical expectation of successful insemination is significantly reduced.

- Laboratory and x-ray services related to covered ART procedures are covered. Covered Services include: Medically Necessary ultrasound, short-term cryopreservation of embryos or preparation of cryopreserved embryos for transfer, analysis, processing, short-term storage/banking of harvested eggs and microfertilization of eggs. Sperm storage/banking is covered only when both male and female partners are actively involved in the infertility treatment and the male partner has undergone a covered surgical sperm retrieval procedure or is undergoing treatment that may cause infertility.

- Preimplantation Genetic Diagnosis (PGD) is covered only when Medically Necessary, as defined in Section 14.

- Semen analysis to determine volume, motility, count and the presence of antibodies is covered.

4. **Cost Sharing for Covered Services**. Please see parts I and II of your Cost Sharing Schedule for information about your share of the cost for Covered Services stated in this subsection. Please refer to:

   - Medical exams, consultations and medical treatments,

   - Medical supplies and drugs: including male or female fertility hormones or drugs administered in a physician's office or Outpatient department of a hospital. (Please contact the State of New Hampshire's pharmacy benefit administrator for information about coverage for fertility hormones and drugs purchased at a pharmacy for "take home" use.)

   - Surgery and anesthesia

   - Laboratory and x-ray tests (including ultrasound).

5. **Limitations**. In addition to the Limitations stated in Section 8, the following limitations apply to this subsection:

   - 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 or treatment for woman who is menopausal or perimenopausal (or for a male partner), unless the woman is experiencing menopause at a premature age.

   - No Benefits are available for cryopreservation of embryos or sperm or for donation, harvesting, banking or storage of sperm or eggs for future use unless the recipient is specifically identified and the expected time of use is appointed by your physician. The services must be provided as part of an active, covered artificial insemination procedure or ART cycle. Otherwise, no Benefits are available for these services.

   - Cost related to donor eggs for women with genetic oocyte defects or donor sperm for men with genetic sperm defects are not covered.

- Selective fetal reduction is covered only when the procedure is Medically Necessary as defined in Section 14.

6. Exclusions. In addition to the Exclusions stated in Section 8, the following exclusions apply to this subsection:

- To be eligible for Benefits, neither partner can have undergone a previous voluntary or elective sterilization procedure. No Benefits are available for reversal of voluntary or elective sterilization or for diagnosis or treatment following the sterilization or sterilization reversal (successful or unsuccessful).

- No Benefits are available for any service related to achieving pregnancy through surrogacy or gestational carriers.

- Sex selection, genetic engineering, sperm penetration assay, microvolume straw technique and hamster penetration test (SPA) are not covered.

- No Benefits are available for egg harvesting or any other infertility procedure performed during an operation not related to an infertility diagnosis.

- Cryopreservation of donor eggs is not covered. Culture and fertilization of oocytes with co-culture of embryos are not covered. Direct intraperitoneal insemination (DIPI) and peritoneal ovum and sperm transfer (POST) are not covered.

- No Benefits are available for ovulation kits and supplies such as thermometers and home pregnancy tests.

Except as stated in this subsection, no Benefits are available for any services to diagnosis the cause of infertility or to treat infertility. No Benefits are available for any service that is an Experimental or Investigational service, as defined in Section 8, II. No Benefits are available for any service that is not Medically Necessary, as defined in Section 14.

If you have questions about Benefit eligibility for a proposed Infertility Service, you are encouraged 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

To be eligible for Benefits, transplants must be approved *in advance* according to your physician and Anthem's Precertification. You and the organ donor must receive services from a Network Provider, Contracting Provider or other Designated Provider, as determined by Anthem. Otherwise, only Out-of-Network Benefits are available.

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

- The Member who undergoes the screening signs an informed consent form authorizing use of the results for the Member's participation in the National Marrow Donor Program, and

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

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

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

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

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

- Allogeneic (HLA identical match) bone marrow transplants for acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma (for children who are at least one year old), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, Thalassemia major and Wiskott-Aldrich syndrome;

- Autologous bone marrow (autologous stem cell support) transplants and autologous peripheral stem cell support transplants for acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, 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 calendar years, or there is evidence of severe complications from TPN. Simultaneous small bowel/liver transplants are covered for children and adults with short bowel syndrome when there is irreversible intestinal failure, an established TPN dependence for a minimum of two calendar years, evidence of severe complications from TPN or evidence of impending end-stage liver failure.

- Travel expenses. Benefits are available for a transplant recipient's transportation, lodging and food expenses, provided that the transplant is a Covered Service under Network Benefits. **Network Benefits are limited to $10,000 per covered transplant per lifetime.**

  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 Section. Covered Services are subject to the cost sharing amounts shown in sections 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 noncovered 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 a Preferred 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. Cost sharing amounts for routine patient care costs are shown in the applicable parts of your Cost Sharing Schedule. For example: your share of the cost for Inpatient services is found in section I of the Cost Sharing Schedule and your share of the cost for Infusion Therapy is found in subsection IV. 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 consistent 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 provider finds or reasonably suspects. No Benefits are available for examinations or services that are 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, such as Precertification rules. Covered Services are subject to the cost sharing amounts as shown under parts I, II and V of your Cost Sharing Schedule.

G. Surgery

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

A Surgical Assistant is a Designated Provider acting within the scope of his or her license that 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 anesthetist who is not the surgeon.

Surgery includes correction of fractures and dislocations, delivery of a baby, endoscopies and any incision or puncture of the skin or tissue that requires the use of surgical instruments to provide a Covered Service. Covered Services are subject to the cost sharing amounts shown under sections I and II of your Cost Sharing Schedule. 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 dependent children who have functional physical deficits due to the birth defect. Corrective surgery for children who do not have functional physical deficits due to the birth defect is not covered under any portion of this 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, Prosthetic Devices and Medical Supplies," 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 A 6. (above). Except as stated in 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 II "Preventative Care" (above in this Section) for diabetes management and nutrition counseling, 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 PCP 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. To be eligible for Network Benefits, Covered Services must be provided by your PCP or Network Provider. Otherwise, only Out-of-Network Benefits are available.

Except for routine vision exams and preventive vision screenings described in Section 7, II, A, 6., "routine vision exams," 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 vision correction and 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.

I. Community Health Education

Reimbursement is available for approved community health education classes. *Benefits are limited as shown on your Cost Sharing Schedule.* This Benefit applies to all Members covered under this Benefit Booklet. Benefits are available for smoking cessation programs, nutrition education, weight management programs, stress management programs, physical activity, yoga, childbirth education, and parenting education. A complete list of participating facilities and a community health education reimbursement form can be found on the State's Human Resource web site. If you have further questions about this benefit, you may call the State of New Hampshire dedicated customer service line. The toll-free number is located on the back of your identification card.

Please note: The Benefits described in this subsection are not available if you are a Retiree, COBRA beneficiary or if you are continuing group coverage under any of the other continuation options described in Section 13, III, "Continuation of Group Coverage."

SECTION 8: LIMITATIONS AND EXCLUSIONS

Please see Section 14 for definitions of specially capitalized words.

I. Limitations

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

Please remember, 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 Referrals, 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 about the appeal process.

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

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

Benefits are subject to the cost sharing amounts as shown under section II "medical supplies" or section IV, "Infusion Therapy," depending on the provider of the services.

Please contact the State of New Hampshire's pharmacy benefit administrator for information about coverage for human growth hormones purchased at a pharmacy.

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

C. Ultraviolet Light Therapy and Laser Therapy for Skin Disorders. Benefits are available for out-of-home ultraviolet light 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 set forth elsewhere in this Benefit Booklet. Please remember, this health plan does not cover any service or supply not specifically listed as a Covered Service in this Benefit Booklet.

Anthem makes determinations about Referrals, 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 about the appeal process.

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, established, or medically documented 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, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

Amounts That Exceed the Maximum Allowable Benefit - Benefits for Covered Services are limited to the Maximum Allowable Benefit. As stated in this 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 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 Service" 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 condition caused by or providing in connection with Cosmetic Services is not covered. No Benefits are available for care furnished for complications arising from Cosmetic Services. Cosmetic Services include 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 "Domiciliary Care" (below) for further information.
- 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, "diabetes management programs," and Section 7, VI, I "Community Health Education Reimbursement," 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, III "Early Intervention Services" and V "Behavioral Health Care," no Benefits are available for services, counseling, therapy, supplies, equipment or programs for behavioral reasons or for Developmental Disabilities.

Experimental/Investigational Services - Except as stated in Section 7, 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 qualified 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, "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.

Routine Care or Elective Care Outside the Service Area – Network Benefits are not available for routine care outside the Service Area of the Designated Network. Only Out-of-Network Benefits are available if you receive routine or elective care outside the Service Area of the Designated Network. Routine care includes, but is not limited to, routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, medication checks, immunizations or other preventive care. Elective care is care that can be delayed until you can contact your PCP, Network Provider or Anthem for direction. Examples of elective care include, but are not limited to: scheduled Inpatient admissions or scheduled Outpatient care.

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 – Except as stated in Section 7, VI, I, "Community Health Education Reimbursement," 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 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), and Section 7, VI, I "Community Health Education", 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." 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, *and*
- Under the terms of an agreement with Anthem or with a Subcontractor, the provider can bill you for amounts exceeding your Copayment, Deductible and/or Coinsurance.

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

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

If services are furnished by an Out-of-Network Provider, you may need to submit your own claim form. Please contact 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. 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 a Pre-Service Claim Denial will be in writing or by electronic means and will include the following:

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

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

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

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

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

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

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

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

BlueCard Program - When you obtain health care services through BlueCard outside the geographic area Anthem serves, the amount you pay for Covered Services is calculated on the **lower** of: The billed charges for your Covered Services, or The negotiated price that the on-site Blue Cross and/or Blue Shield Plan passes onto Anthem.

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

Statutes in a small number of states may require the 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.

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

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

Anthem reserves the right to pay either you or the hospital or any other provider. You cannot assign any Benefits or monies due under this 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.

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 or Referral rules apply, as stated in Section 1, III, "Precertification", Section 3 "Network Benefits" and Section 4, "Out-of-Network Benefits".

II. Definitions

The following definitions apply to the terms of this Section:

Primary means the health care plan or policy that is responsible for processing your claims for eligible benefits first. When this health care plan is the Primary plan, Anthem will provide the full extent of Benefits for services covered under this 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.

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 a Network Provider contracts with Anthem to accept a negotiated amount as payment in full when Anthem is the Secondary payer and such negotiated amount differs from the Primary payer's arrangement, Anthem's negotiated amount will be the Allowable Expense used to determine Secondary Benefits. The total amount in payments and/or services provided by all payers combined will not exceed Anthem's Maximum Allowable 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. Examples of these types of plan provisions include, but are not limited to: managed care requirements for second surgical opinions, Inpatient and Outpatient precertification requirements and rules about access to care (such as network restrictions and referral rules).

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

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 your Group, your status as an active employee, your age and the reason that you are eligible for Medicare. If Medicare is the Secondary plan according to MSP laws, coverage under this Benefit Booklet is Primary. If Medicare is the Primary plan according to MSP laws, the Group coverage for which you are eligible is Secondary.

  If you are entitled to Medicare benefits when you enroll in this plan, you must inform your Group Benefits Administrator and state this information on your enrollment form. If you become entitled to Medicare benefits after you enroll, you must inform your Human Resource or Payroll Representative 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 (including the rules for children of separated or divorced parents).

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

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:

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

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

1. For a dependent child whose parents are married or are living together, whether or not they have ever been married, the following "birthday rule" applies:

   a. The plan of the parent whose birthday falls earlier in the calendar year is Primary, or

   b. If both parents have the same birthday, the plan that has covered the parent the longest is Primary.

2. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

   a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is Primary. This rule applies to plan years commencing after the plan is given notice of the court decree, or

   b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of 1 above (the birthday rule) shall determine the order of benefits.

   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of 1 (above) "birthday rule" shall determine the order of benefits.

   d. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

      1). the plan covering the Custodial parent;

      2). the plan covering the spouse of the Custodial parent;

      3). the plan covering the non-Custodial parent; and then

      4). the plan covering the spouse of the non-Custodial parent.

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

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

- **Active, Retired or Laid-off Employee.** The plan that covers a Member as an active employee (that is - an employee who is neither laid off nor retired) is Primary. The plan covering that same Member as a retired or laid-off employee is Secondary. The same rule applies if a Member is a dependent of an active employee and that same Member is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the "Non-Dependent/Dependent" rule (above in this subsection) can determine the order of benefits.
- **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. This rule does not apply if the "Non-Dependent/Dependent" rule (above in this subsection) can determine the order of benefits.
- **During Military Deployment.** In the event of a State of New Hampshire employee's military deployment for which federal health care benefits are available, the federal health benefits are primary to the Benefits provided under this plan.

- **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 your employer 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 payment 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 for the Subscriber and covered dependents.

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 coverages and/or insurance policies or benefits you may have in addition to Anthem coverage. Other health coverages, 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 Anthem's rights,
- 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 and covered Dependents.

Section 11: MEMBER SATISFACTION SERVICES AND APPEAL PROCEDURE

Please see Section 14 for definitions of specially capitalized words.

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

I. Member Satisfaction Services

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 network directory, or replacement of identification cards),
- Make sure your suggestions are brought to the attention of the appropriate persons, and
- Provide assistance to you (or your authorized representative) when you want to file an internal appeal.

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

Anthem will respond to most of your questions or requests at the time of your call or within a few days. Please see "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 a Network 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

Introduction. 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 section explains the internal appeal procedure.

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

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

- You submit a written statement in a form prescribed by Anthem acknowledging the representation. To find out about required authorization forms, please contact Customer Service. The toll-free phone number is 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.** 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 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 180 days of Anthem's notice stating the results of your first level internal appeal. You do not have to re-send the information that you submitted for your first level internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

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

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

  Ongoing Urgent Care services will be continued as directed by your physician without liability to you until you are notified. You will be held harmless for the cost of the care under review, pending the outcome of the internal appeal. 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:

  1. 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

  2. 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,

  3. 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,

  4. 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 or 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.

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 independent External Review, provided that:

- You have completed the internal appeal process described above 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 and 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 second level 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 Appeals 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 your employer - 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 Anthem changes the provisions of this Benefit Booklet, your employer - the State of New Hampshire will be given reasonable notice before the effective date of the change. Anthem will provide your employer - the State of New Hampshire with at least 30 days prior notice in the event of any renewal premium rate increase. If your employer - the State of New Hampshire continues premium payments as required under your employer's agreement with Anthem, you will be considered to have accepted the new Benefits and/or rates and they will be binding to the Benefit Booklet as of their effective date. Any notice which Anthem gives to you will be in writing and mailed to you at the address as it appears on our records, or, when permitted by applicable law, in care of your employer - the State of New Hampshire, which sends the premium to Anthem.

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, Precertification, Medical Necessity, Experimental/Investigational services, new technology, whether surgery is cosmetic, whether charges are consistent with Anthem's Maximum Allowable Benefit, whether or not a service is a Covered Service and all other matters concerning administration and operation of this managed health care plan, based on the terms of this 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 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 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 your employer , 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 COVERAGE

Please see Section 14 for definitions of specially capitalized words.

I. Eligibility

By accepting membership in this health plan, you agree to give Anthem information that Anthem needs to verify coverage eligibility.

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

A. Your Spouse. Your spouse is eligible to enroll unless you are legally separated. Throughout this Benefit Booklet, any reference to "spouse" means:

- The individual to whom the Subscriber is lawfully married, as recognized under the laws of the state where the Subscriber lives, or

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

Throughout this Benefit Booklet any reference to "marriage" means a lawful marriage or lawful civil union. References to legal separation apply to marriage and civil union legal separations. References to divorce apply to the termination of a lawful marriage or lawful civil union.

The Subscriber's ex-spouse, following legal separation or divorce is not eligible to enroll.

B. Your unmarried children who are less than 19 years old. "Children" include: your natural children, legally adopted children, children for whom you are the legal guardian, stepchildren who are dependent upon the Subscriber for support; and children for whom you are the proposed adoptive parent and who have been placed in your care and custody during the waiting period before the adoption becoming final. Foster children and grandchildren are not eligible for coverage. Please see "Special Enrollees" and "Newborn Children" in this Section for more information.

C. Your unmarried Student children who are between 19 and 25 years old. "Student" children are dependent children between age 19 and 25 who are enrolled and are in full-time continuous attendance during the academic year (enrolled in at least 12 credit hours) at an accredited secondary school, college or university, and for who a Student Certification form is on file with Anthem.

STUDENT EXCEPTION: MEDICALLY NECESSARY LEAVE OF ABSENCE FROM SCHOOL

Full Time Students who meet all eligibility requirements for dependent children will continue to be covered dependent children during a medically necessary leave of absence from school, subject to the terms of this subsection. To maintain eligibility, the dependent must be:

- Unmarried, and

- Under age 25, and

- Must be absent from full-time attendance an accredited secondary school, college or university where the student was enrolled as a full-time student immediately before full-time attendance ceased due to a medically necessary leave of absence. The term "full-time" is defined by the institution where the student is enrolled when the leave of absence begins.

- The student's attending physician must submit certification to Anthem documenting the medical necessity of the leave of absence.

- Anthem will consider the physician's certification to be prima facie evidence that the student is eligible for this exception for a period not to exceed 12 months or the date on which coverage would otherwise end pursuant to the age limit stated above or pursuant to any other cause of ineligibility, whichever comes first. Coverage under the terms of this exception begins on the date that the student's medically necessary leave of absence from school begins, as certified by the student's attending physician. Any breaks in the school semester will not disqualify the student from coverage under this exception.

To best facilitate the administration of benefits under this plan, Anthem suggests that you submit the physician's certification within 30 days of the date your student's medically necessary leave of absence from school begins.

Please note: For the purposes of this subsection, the definition of "Medically Necessary," found in Section 14 does not apply. Except for this subsection, Anthem's definition of Medical Necessity applies to every portion of this Certificate.

D. Your unmarried Incapacitated Children. Incapacitated Children are the Subscriber's unmarried dependent children who are 19 years old or older and who are mentally or physically incapable of earning their own living on the date that eligibility under this Benefit Booklet would otherwise end due to age. The disability must have occurred before the child reached age 19 and must have occurred while the dependent was a covered dependent child, or it must have occurred between the ages of 19 and 25 while the child was a covered dependent Student. Incapacitated dependents may remain covered as long as their disability continues and as long as they are financially dependent on the Subscriber and are incapable of self-support. Anthem must receive an application for this incapacitated status, and medical confirmation by a physician of the extent and nature of the disability, within 31 days of the date coverage would otherwise end. Anthem's Medical Director must certify that your child is incapacitated. Anthem may periodically request that the incapacitated status of your child be recertified. If the child's disability ends, he or she may elect to continue group coverage as stated in III, A, "Continuation of Coverage under COBRA."

When Coverage Begins – For **newly hired individuals**, the Subscriber and all eligible dependents are **first eligible to enroll** within 31 days of the date of hire. Eligible dependents are defined above in A-D. Provided that the Subscriber and eligible dependents enroll within 31 days of the date of hire, coverage under this Benefit Booklet begins on the first day of the month following one month of employment after the date of hire.

If you, the Subscriber, are already enrolled, **new family members are first eligible to enroll** within 31 days of meeting one of the eligibility definitions in A to D (above). Provided that the new family member enrolls within 31 days of first becoming eligible, coverage for the new family member is effective on the date of eligibility.

Please contact your Human Resource or Payroll Representative if you have other questions about the effective date of this coverage.

If the Subscriber or any eligible dependent does not enroll when first eligible, enrollment cannot occur until the State of New Hampshire's next open enrollment period. Exceptions exist for "Special Enrollees" (below).

Special Enrollees - Special Enrollees are employees and/or eligible dependents 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:

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

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

- Voluntary or involuntary termination of the other health care coverage (including exhaustion of 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 dependent otherwise loses eligibility (for example: a child attains an age that causes him or her to lose eligibility status in another plan, but the child is eligible to enroll in this health care plan),
- Employer contributions toward the other coverage end (regardless of whether the person is still eligible for the other coverage),
- For a person covered under an individual HMO policy that does not provide benefits to individuals who no longer reside, live or work in the Service Area, loss of eligibility occurs when the individual loses coverage because he or she no longer resides, lives or works in the Service Area. For a person with group HMO coverage, the same rule applies, provided that there is no other coverage offered by the other health care plan,
- Loss of eligibility because the other plan ceases to offer health care benefits to a class of similarly situation individuals,
- In a multiple-option group plan, an issuer or insurer providing one of the options ceases to operate in the group market (exception: this provision does not apply if the group plan provides a current right to enroll in alternative coverage),
- An individual incurs a claim that meets or exceeds the other plan's lifetime benefit maximum.
- The employee's or eligible dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility. Provided that your enrollment process is completed within 60 days after the eligibility is determined, this coverage will become effective on the first day of the month after you enroll.

Court ordered enrollment. This event applies when a court has ordered coverage for a lawful spouse or dependent 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. This provision does not apply to divorced or legally separated spouses.

New dependent due to marriage. Employees and eligible dependents that are not covered under this health plan may enroll due to marriage at the same time as the new spouse. Provided that you and your spouse complete the enrollment process within 30 days of the date of marriage, this Benefit Booklet will become effective on the date of marriage.

New dependent due to birth, adoption or placement for adoption. Employees and/or spouses and other eligible dependents that 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 you enroll within 30 days of the birth, adoption or placement, this Benefit Booklet will become effective on the date of the birth, adoption or placement.

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

Newborn Children - Your newborn child is eligible for Benefits described in this Benefit Booklet for up to 31 days from the child's date of birth, as long as your coverage is in effect during that time. However, you must enroll the child as a covered dependent child. To maintain continuous coverage for your newborn, you must complete the enrollment process within 31 days of the child's birth.

If you do not complete the enrollment process within 31 days after birth, your child's eligibility for Benefits will end at midnight on the 31st day after the date of birth and you will not be able to enroll your child until the State of New Hampshire's next open enrollment period.

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

Effective Date for Benefits. The effective date of your coverage under this Benefit Booklet is determined by your employer – 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 your employer – 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 your employer- the State of New Hampshire if you need to add a Member to your coverage or when a Member is no longer eligible for coverage under your Benefit Booklet.

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

Contact your Human Resource or Payroll Representative 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 employer- 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.

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 your employer- 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. Cancellation for nonpayment is considered cancellation by your employer – the State of New Hampshire and Subscriber, and not by Anthem.

- Your employer 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 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 your employer, an employee, dependent or an employee's representative.

- Your employer 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 your employer – 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 of 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 employees.

If You Are No Longer a Member of the State of New Hampshire Employer Group - If your employment terminates, your coverage will terminate on a date as determined by your employer – 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.

Termination of Your Marriage - If you become divorced or legally separated, the coverage of the Subscriber's spouse will terminate on the first of the month following the date of divorce or legal separation. The Subscriber must notify the State of New Hampshire about the change in marital status within 60 days of such change. However, the Subscriber's failure to make notice of the change does not prohibit the State of New Hampshire or

Anthem from terminating the membership of an individual who no longer meets the definition of a covered spouse. Please see III (below), "Continuation of Group Coverage" for information about coverage options.

Termination of a Child's Coverage - A Dependent child's coverage or an incapacitated Dependent's coverage under this Benefit Booklet will terminate on the first day of the month following date on which the dependent:

- Marries, or
- No longer meets the age requirement or any other requirement stated in I above for dependent children, including full and part time students, except for Incapacitated Dependent, or
- No longer meets the eligibility requirements for an Incapacitated Dependent. The Subscriber must notify the State of New Hampshire about the change in dependent status within 30 days of the change. Please see III (below), "Continuation of Group Coverage" for information about coverage options.

Other Situations Under Which This Coverage 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 or Member in connection with information provided in the enrollment process 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 any Member's identification card or if the Subscriber or Member otherwise cooperates in the unauthorized use of such Member's identification card.

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

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.

A. Continuation of Coverage under "COBRA" - The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a continuation law that applies only if your employer had an average of 20 or more benefit-eligible employees during the year. If you have any questions about COBRA continuation, contact your Human Resource or Payroll Representative right away. The following is only an outline of your COBRA rights and responsibilities.

If your employment is terminated for any reason (except for gross misconduct) or your hours of employment are reduced so that you do not qualify to participate in your employer health care plan, you and your covered dependents 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, nondisabled 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 dependents 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 dependent 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 dependent 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 dependent 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.

In the event you become ineligible for coverage in your employer health plan, you must notify your Human Resource or Payroll Representative within 30 days. You **must notify** your Human Resource or Payroll Representative within 60 days of the date of your divorce or legal separation and within 60 days of the date your enrolled dependent(s) no longer meet the definition of a dependent. Your employer – 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 your employer 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 your employer 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.

B. 39-Week Extension of Group Coverage. New Hampshire law provides for up to 39 weeks of continued group coverage when the group health plan ends for all employees for any reason. The 39 week extension is available only if your group coverage ends as stated above, and:

- You were a Member on the date that group coverage ended, and
- You were insured under the group plan for at least 60 days, and
- You do not have and you are not eligible for other similar coverage, such as coverage under another group or individual accident and health insurance plan, Medicare or Medicaid.

Premium is the same group rate plus a two percent administrative fee. Coverage will continue until the earliest of one of the following events:

- For up to 39 weeks, or
- Until the required premium is not paid on time, or
- Until the continuing member becomes eligible for benefits under another group plan or Medicare.

The 39-week extension is not available if you are eligible for other group coverage or eligible for Medicare benefits. If the State of New Hampshire canceled coverage with Anthem for all employees because the State of New Hampshire contracted for coverage with another carrier, you are always considered to be eligible for coverage under the new plan and you are not eligible for a 39-Week Extension.

The State of New Hampshire's Responsibility to Notify Anthem. Your employer – the State of New Hampshire is responsible to notify Anthem about termination of the coverage described in this Benefit Booklet.

Anthem's Responsibility to Notify You. Within 30 days of plan termination, Anthem will notify you of your option to elect a 39-Week extension.

Your Responsibility to Notify Anthem and Pay Premium. To elect coverage under a 39-Week extension, you must provide written notice of election to Anthem together with the required premium. The notice and payment must be provided within 31 days of the date of Anthem's notice to you. Premium will be paid directly to Anthem.

SECTION 14: DEFINITIONS

This Section defines some of the words and phrases found throughout 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. Your employer - the State of New Hampshire has contracted with Anthem to provide certain services, including claims processing, administration and utilization management services, for this managed health care Plan described in this Benefit Booklet.

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 documents which describe the terms and conditions of coverage under this health plan. The Benefit Booklet includes this document and any endorsements and/or riders that amend this document.

Benefit(s) 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 has a standard written payment agreement with the local Blue Cross and Blue Shield plan. BlueCard Providers do not have written payment agreements with Anthem. Therefore, they are not Network Providers.

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 a Network Provider.

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

Covered Service means the services, products, supplies or treatment specifically 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, or by any endorsement, rider or amendment to 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 Network Providers and requirements about Precertification from Anthem.

Designated Network means a group of Network Providers (PCPs, other physicians, specialists, facilities, and other health care providers) who have network payment agreements directly with the same Local Plan make up a "Designated Network." All Designated Networks combined comprise the entire New England Network.

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 including Doctors of Medicine (MDs) and Advanced Practice Registered Nurses (APRNs) 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, Network Diabetes Education Providers, Eligible Behavioral Health Providers, chiropractors, dentists and oral surgeons are Designated Providers only to the extent of coverage stated in this Booklet. New Hampshire Certified Nurse Midwives (NHCMs) are Designated Providers only when acting within the scope of practice defined in New Hampshire law. 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 (most often your PCP), or

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

Developmental Disabilities means chronic mental or physical impairments that occur at an early age, are likely to continue indefinitely, result in substantial functional limitations and require special care and services of lifelong or extended duration. Such disabilities include, 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 which 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 affiliated New England Blue Cross and Blue Shield Plan that administers written agreements made directly between the plan and Network Providers in the Designated Network.

Maximum Allowable Benefit (MAB) means the dollar amount available for a specific Covered Service. Anthem determines the Maximum Allowable Benefit (MAB) for approved Covered Services that you receive in New Hampshire. Anthem also determines the MAB for approved 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 a Network Provider or BlueCard Provider located outside New Hampshire. Network Providers and BlueCard Providers accept the MAB as payment in full.

Medical Director means a physician licensed under NH law and employed by Anthem who 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 reduced or 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 Network Providers and requirements about Precertification from Anthem.

Member means a Subscriber and any spouse of a Subscriber or dependents of the Subscriber or of the Subscriber's spouse covered under this Benefit Booklet.

Network Behavioral Health Provider means a hospital or other Eligible Behavioral Health Provider, as defined in Section 7, V who has an agreement with Anthem or with another Local Plan to make Covered Behavioral Health Care (Mental Health and Substance Abuse) care available to Members.

Network Birthing Center means a Birthing Center that has a written agreement directly with Anthem or another Local Plan to provide Covered Services to Members.

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

Network 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 or with the Local Plan to provide nutrition counseling services to Members.

Network Primary Care Provider (PCP) means a Network Provider who has a written agreement with Anthem or another Local Plan regarding, among other things, willingness to provide Covered Services to Members as a Primary Care Provider.

Network Provider means any Designated Provider in your Service Area that has a Network written agreement directly with Anthem or the Local Plan to provide Covered Services to Members. Please see Section 7, V, "Behavioral Health Care" for the definition of eligible behavioral health providers.

Network Service means a Covered Service that you receive from a Network Provider.

Network Urgent Care Facility means a licensed hospital's facility that provides urgent health services for diagnosis, care and treatment of illness or injury and that has a written payment agreement directly with Anthem to provide such services to Members. A Network Urgent Care Facility may be free-standing or a facility located in the Outpatient department of a hospital.

Network Walk-In Center means a licensed free-standing center that provides episodic health services without appointments for diagnosis, care and treatment of illness or injury and that has a written payment agreement directly with Anthem to provide such services to Members.

New Hampshire Certified Midwife (NHCM) means an individual who is certified under New Hampshire law to provide covered routine maternity care Services to Members.

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.

Out-of-Network Provider means any Designated Provider that is not a Network Provider. Providers who have not contracted or affiliated with Anthem's designated Subcontractor(s) for the services that are Covered Services under this Benefit Booklet are also considered Out-of-Network Providers.

Out-of-Network Service means a Covered Service that is furnished by an Out-of-Network Provider.

Outpatient means any care received in a health care setting other than an Inpatient setting ("Inpatient" is defined above).

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

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

- Anthem reduces or denies Benefits, *and*
- The provider can bill you for amounts exceeding your Copayment, Deductible and/or Coinsurance under the terms of an agreement with Anthem.

Precertification or Precertify means Anthem's or the Local Plan'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 *in advance* from Anthem. Requests for Precertification 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 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 in this Benefit Booklet. 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 is required to take under the terms of this Benefit Booklet.

Referral means a specific recommendation by a Member's PCP that the Member should receive evaluation or treatment from a specific Designated Provider. A PCP's recommendation is a Referral only to the extent of the specific services approved and referred by the PCP. A general statement by a PCP that a Member should seek a particular type of service or provider does not constitute a Referral under this Benefit Booklet. A Referral does not guarantee or imply coverage for those services or procedures. A Referral from your PCP is not required for services furnished by Network Providers. Please see Section 3, IV for information about exceptions for Out of Network services.

Service Area means the geographic area within which all Designated Networks combined are located.

Short Term General Hospital means a health care institution having an organized professional and medical staff and Inpatient facilities which 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 Employee or Retiree, to whom this Benefit Booklet is issued.

Urgent Care Claim means any 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.

Urgent Care Facility means a licensed hospital's facility that provides urgent health services for diagnosis, care and treatment of illness or injury. An Urgent Care Facility may be free-standing or a facility located in the Outpatient department of a hospital.

Walk-In Center means a licensed free-standing center that provides episodic health services without appointments for diagnosis, care and treatment of illness or injury.

You, Your and Yours - Unless specifically stated otherwise, the words "you," "your" and "yours" refer to you, the person to whom this Benefit Booklet is issued (the Subscriber) and your covered spouse and covered dependents-collectively the Members.

Anthem