

Healthy Kids Silver Member Coverage Certificate

What you need to know about your health plan

Anthem Blue Cross and Blue Shield is located at
3000 Goffs Falls Road, Manchester, New Hampshire 03111-0001
Our toll-free telephone number is 1-800-870-3057



Foreward

The Healthy Kids Silver program is made available to the children of New Hampshire by the New Hampshire Healthy Kids Corporation (NHHKC), Anthem Blue Cross and Blue Shield (Anthem) and its subsidiary, Matthew Thornton Health Plan.

We welcome your membership and invite you to contact Anthem whenever you have a question or concern about your coverage. We also welcome your comments and suggestions. Our Customer Service Representatives are available during business hours to answer your questions and to make sure that your suggestions reach the appropriate persons here at Anthem. Please have your identification number at hand (including the "YGK" prefix) when you contact us. Your identification number is on your identification card. Our Customer Service Representative will ask you for your identification number so that we can locate your important records and assist you without delay.

Please call Anthem during business hours at 1-800-870-3057. You can write to us at this address.

Type of Communication	Mail to
Inquiries – Benefit questions or claim status	Anthem Blue Cross and Blue Shield P.O. Box 660 North Haven, Connecticut 06573-0660
Appeals – Review of a claim 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



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The New Hampshire Healthy Kids Corporation (NHHKC) was established by the New Hampshire legislature. It is a private, non-profit corporation deemed to be a "public instrumentality" performing "public and essential functions of the state" in accordance with NH RSA 126-H:2. One of those functions is to provide preventive health care and comprehensive health insurance coverage for children who meet the eligibility standards established by the New Hampshire Healthy Kids Corporation.

The Healthy Kids Silver program is administered by Anthem Blue Cross and Blue Shield (Anthem) and underwritten by its subsidiary, Matthew Thornton Health Plan. Anthem Blue Cross and Blue Shield is licensed as an Accident and Health insurer in accordance with NH law. Matthew Thornton Health Plan is a licensed health maintenance organization that has a certificate of authority from the Commissioner of Insurance of the State of New Hampshire.

Throughout this Certificate, "we," "us," and "our" refer to Anthem. "You," "your" and "yours" refer to the Member to whom this Certificate is issued.

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How Your Plan Works

Section 1

Please see Section 11 for definitions of specially capitalized words.

I. Health Care Through Healthy Kids Silver

This is your Healthy Kids Silver Member Coverage Certificate. It describes a partnership between you, your Primary Care Physician, the New Hampshire Healthy Kids Corporation (NHHKC) and Anthem. You have the right to the Benefits described in this Certificate. Important limitations and exclusions are also explained in this Certificate.

We may issue riders or endorsements that amend this Certificate by describing other Covered Services or limitations. Please read your Certificate, riders and endorsements carefully, because they explain your Benefits and important limitations of coverage.

II. Copayments

You share in the cost of your Covered Services through Copayments. A Copayment is a fixed dollar amount that you are responsible for paying each time you receive a Covered Service. For example, you pay a \$10 Copayment each time you visit your Primary Care Physician's office. You pay a \$50 Copayment each time you use a hospital emergency room. **Please see your Cost Sharing Schedule (enclosed with this Certificate) for other Copayment amounts that may apply to other Covered Services.**

III. Your Network Primary Care Physician (PCP)

In this Certificate, your Primary Care Physician is called your PCP. To be eligible for Benefits, you must first select a PCP—someone with whom you develop a strong, trusting relationship, who knows your medical history and who has an interest in working with other Designated Providers to be sure that your health care is coordinated. PCPs include family practitioners, general practitioners and pediatricians.

Always talk to your PCP before you receive health care services. Your PCP must furnish your Covered Services or arrange for you to receive Covered Services from another Network Provider.

- **Selecting a PCP.** Each Member selects a PCP from the Network Directory. New Hampshire Healthy Kids Corporation provides the directory when you enroll and provides instructions on how to select a PCP.

- **Changing a PCP.** If you want to change your PCP, call our Customer Service Center or write to us. The change will become effective on the day you call or on the day we receive your written request, unless you request an effective date that comes after the date of your call or letter. We will honor your request for a later effective date. You can change your PCP for any reason. We may inquire about the reason for changing a PCP because your information helps us to maintain the quality of our Network.

IV. The Network

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. Physicians and other Designated Providers who are not members of the Network are referred to as Out-of-Network Providers throughout this Certificate.

V. Individual Case Management

Anthem provides Individual Case Management services to Members who have experienced an inpatient hospital admission or a catastrophic illness or injury. At times, Individual Case Management may be limited to coordinating Covered Services for a Member following an inpatient hospital admission. Examples of illnesses or injuries that may require more intensive Individual Case Management coordination are: head injury, cancer, HIV/AIDS, cardiac disease, organ transplant and conditions associated with premature birth.

Anthem's Case Manager will facilitate communication between the members of a patient's treatment team. The Case Manager will also provide information about the patient's Benefits and will inform the patient of any appropriate federal, state or community resources that may be available to the patient and his or her family.

VI. Services Must Be Medically Necessary

Anthem will pay Benefits only if you receive Covered Services that are Medically Necessary, as determined by your PCP and Anthem or by the Behavioral Health Network (BHN). This requirement applies to all sections of this Certificate. Please see Section 11 for the definition of "Medically Necessary."

Referral to Specialists and Plan Approval

Section 2

Please see Section 11 for definitions of specially capitalized words.

I. Referral to Network Specialists

To be eligible for Benefits, always talk to your PCP *before* you seek health care. If your PCP determines that you need services at a hospital or from a specialist (such as a surgeon, physical therapist or cardiologist), your PCP will write a Referral for your care. With few exceptions, your PCP will direct you to a Network Provider for your specialized care.

A Referral is your PCP's written approval for Covered Services. It describes the specific services and the number of visits or treatments that are authorized. Benefits are not available if you do not obtain your PCP's Referral *in advance*. No Benefits are available for services that exceed the limits of your PCP's Referral. *With few exceptions, you are responsible for paying the cost of services that are not authorized in advance by your PCP's Referral.*

II. When a Referral Is Not Required

With few exceptions, Benefits are available *only* when your PCP directly provides the care or approves the care by writing a Referral *in advance*. However, you do not need to obtain your PCP's Referral for the following services:

- A female Member is not required to obtain a Referral from her Primary Care Physician (PCP) in order to access obstetrical or gynecological care *from a Network Obstetrician/Gynecologist*. Benefits are available for covered obstetrical or gynecological care *furnished by any Network Obstetrician/Gynecologist*. Benefits are also available if a Network Obstetrician/Gynecologist refers a female Member to *another Network Obstetrician/Gynecologist for obstetrical or gynecological care*. Network Obstetrician/Gynecologists are listed in the Directory of Network Specialists.

Examples of obstetrical or gynecological care are:

- obstetrical care, such as pregnancy tests, routine maternity care (including prenatal care, delivery and postpartum services), care for high risk pregnancies, complications of pregnancy, and care related to postpartum complications,
- gynecological care, such as an annual gynecological visit (including related laboratory and radiological tests), mammograms or the treatment of endometriosis,
- follow-up care for obstetrical or gynecological conditions identified in the course of maternity care or as a result of an annual gynecological visit,

- laboratory and radiological tests and inpatient admissions ordered by a Network Obstetrician/Gynecologist for an obstetrical/gynecological condition.

Important notes:

- Except as stated in this article, Benefits are available for the services of a Network Specialist *other than* an Obstetrician/Gynecologist (such as a Urologist) *only* if you obtain a Referral from your PCP *in advance*.
- Benefits are available for Out-of-Network Services *only* if you obtain a Referral from your PCP and Precertification from Anthem Blue Cross and Blue Shield *in advance*.
- Benefits are available for treatment of general medical conditions (other than [obstetrical or] gynecological conditions) *only* if your PCP *furnishes the care or authorizes a Referral in advance*. Examples of general medical conditions include (but are not limited to): breast or cervical cancer, pregnancy or nonpregnancy-related hemorrhoids, high blood pressure, diabetes, blood disorders, kidney disorders or digestive tract disorders. Your PCP must furnish the care for such conditions or authorize a Referral *in advance*. Otherwise, no Benefits are available.
- Behavioral Health Care (Mental Health and Substance Abuse Care). Please see Section 4, article III. You must obtain Precertification from the Behavioral Health Network *before* you receive Behavioral Health Care;
- Emergency Care, as described in Section 3;
- emergency ambulance transportation, as described in Section 4, article II, 2;
- a routine vision exam furnished by a Network Provider (limited to one exam each year). Please see Section 4, article II, 16 for more information about routine vision exams;
- prescription drugs furnished by a Network Pharmacy.
- covered hearing aids. Please see Section 4, article II, 9 for more information about covered hearing aids.

III. Precertification from Anthem

Anthem must approve certain Referrals *before* you receive the care. Our written approval is called "Precertification." Examples of Referrals that must be approved *in advance* by Anthem are: Referrals for Out-of-Network Services, inpatient admissions and outpatient surgery. Your PCP or Network Provider is

responsible for contacting Anthem for Precertification when required. Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of the Certificate in effect on the date you receive the service.

Whenever Anthem reviews a Referral, Anthem's 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. Our Medical Director may determine that the proposed service is not a Covered Service or that the proposed service is not Medically Necessary. Our Medical Director may require that you receive your service 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. Anthem will issue the determination to the Provider

and to you in our Precertification letter. The decision to receive or decline to receive health care services is the sole responsibility of the Member.

Note: You must call Anthem to obtain Precertification *before* you purchase certain prescription drugs. Please see Section 4, article VI for more information.

IV. Precertification for Behavioral Health Care

You must obtain Precertification from the Behavioral Health Network (BHN) *before* you receive **Behavioral Health Care**. Otherwise, no Benefits will be available. Please see Section 4, article III, "**Behavioral Health Care**" for more information.

Emergency Care

Section 3

Please see Section 11 for definitions of specially capitalized words.

This Section will help you determine when you may obtain Benefits for Emergency Care without contacting your PCP or the Behavioral Health Network (BHN) in advance.

I. Urgent Care

Whenever possible, contact your Primary Care Physician (PCP) for direction before you receive urgent medical care. For example, contact your PCP before seeking care for conditions such as sprain, sore throat, rash, earache, minor wound, moderate fever or muscle pain. Otherwise, no Benefits will be available.

Whenever possible, contact BHN before you receive urgent care for a Mental Disorder or Substance Abuse Condition. For example, contact BHN before you receive medication checks or to access care for outpatient mental health services. Otherwise, no Benefits will be available.

II. Emergency Care

It may not always be possible or safe to delay treatment long enough to consult with your PCP or BHN *before* you seek care. In such emergency situations, you do not need to contact your PCP or BHN in advance. Go to the nearest emergency facility immediately for Emergency Care. Call 911 for assistance if necessary.

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

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

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

III. Emergency room visits for Emergency Care

Benefits are available for Emergency Care in any licensed hospital emergency room, provided that:

- you obtain approval from your PCP, your Network Obstetrician/Gynecologist or from BHN *in advance*, or
- your condition meets the definition of Emergency Care as stated in II (above).

Otherwise, no Benefits are available.

You pay the \$50 Emergency Room Copayment each time you visit an emergency room. The Copayment is waived if you are admitted to the hospital as a bed patient through the emergency room.

IV. Inpatient Admissions to a Hospital for Emergency Care

- **Medical/surgical admissions for Emergency Care.** Benefits are available for an inpatient admission for Emergency Care provided that:
- you obtain a Referral from your PCP or from your Network Obstetrician/Gynecologist *in advance*, or
- your condition meets the definition of Emergency Care as stated in Article II (above), and
- you, or someone acting for you, call your PCP for a Referral (for pregnancy-related care, call your Network Obstetrician/Gynecologist), or call Anthem at 1-800-531-4450 for Precertification, within 48 hours (or on the next business day after the date of your admission, whichever is later).

Otherwise, no Benefits are available.

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.

Important note: An admission to deliver a baby is an expected event commonly occurring at the end of a pregnancy. Therefore, routine maternity admissions are not considered to be Emergency Care admissions, even though you may not know the exact date of your admission in advance. Your prenatal care must be furnished by your PCP or by a Network Obstetrician/Gynecologist. Otherwise, no Benefits will be available for your routine maternity admission. Your PCP or Network Obstetrician/Gynecologist will notify Anthem about your admission as required.

- **Behavioral health (Mental health or substance abuse) admissions for Emergency Care.** Benefits are available for an inpatient admission for Emergency Care for Behavioral Health Care provided that:
- you obtain Precertification from BHN *in advance*, or
- your condition meets the definition of Emergency Care as stated in article II (above), and
- you (or someone acting for you) call BHN at 1-800-228-5975 for Precertification within 48 hours (or on the next business day after the date of your admission, whichever is later).

Otherwise, no Benefits are available.

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

V. Limitations

In addition to the Exclusions listed in Section 5, the following limitation apply to Emergency Care:

- **"Follow-up" care** is any related Covered Service that you receive *after* your initial Emergency Care. To be eligible for Benefits **for medical/surgical conditions**, your follow-up care must be furnished by your PCP or authorized *in advance* by your PCP's Referral. Otherwise, no Benefits are available.

To be eligible **for Benefits for Mental Disorders or Substance Abuse Conditions**, your follow-up care must be authorized *in advance* by BHN. Otherwise, no Benefits are available.

- When determining whether or not your services meet the definition of Emergency Care, Anthem and BHN will consider *not only the outcome* of your emergency room visit or hospital admission, *but also the symptoms that caused you to seek the care*. In order to determine eligible Benefits, Anthem and BHN reserve the right to review medical records after you have received your services.
- Emergency Care does not include routine or elective care. Routine care includes, but is not limited to, routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, medication checks, immunizations or other preventive care. Elective care is care that can be delayed until you can contact your PCP for direction. Examples of elective care include, but are not limited to: scheduled inpatient admissions to a hospital, skilled nursing facility or physical rehabilitation facility and scheduled outpatient care at a hospital or in a doctor's office. Emergency Care does not include maternity admissions that are not authorized *in advance* by a Network Obstetrician/Gynecologist.
- If you are admitted as a bed-patient to an Out-of-Network Hospital for Emergency Care, Benefits are provided only until Anthem and your PCP or BHN determines that your condition permits your transfer to a Network Hospital.

Your Benefits

Section 4

Please see Section 11 for definitions of specially capitalized words and phrases.

You have the right to the Benefits described in this Section. Please read this Section carefully, because limitations sometimes apply to your coverage. Please see Section 5 for information about services that are not covered.

With few exceptions, Benefits are available only when your PCP furnishes Covered Services or approves the services *in advance* by authorizing a Referral to a Network Provider.

The Behavioral Health Network (BHN) authorizes your Behavioral Health Care (Mental Health and Substance Abuse Care). Please see article III.

All Covered Services must be furnished or ordered by a Designated Provider. Preventive health services are listed in article II, number 16. All other Covered Services must be Medically Necessary for the diagnosis and treatment of disease, illness, or injury, or for maternity care, and must be furnished by a Designated Provider.

Please see your Cost Sharing Schedule (enclosed with this Certificate) for specific Copayment amounts.

I. Hospital Care

Please see article IV for information about Organ and Tissue Transplant Services.

- 1. Inpatient Care in a Short-term General Hospital.** Benefits are available for inpatient services customarily furnished by a Short-term General Hospital. This includes maternity admissions. Covered Services include semi-private room and board, nursing care, pharmacy services and supplies, diagnostic tests, operating room charges, and delivery room charges. Newborn nursery charges are not covered. Your services must be furnished by a Network Provider, according to the Referral of your PCP or your Network Obstetrician/Gynecologist.
- 2. Care in a Skilled Nursing Facility or Physical Rehabilitation Facility.** Benefits are available for approved Medically Necessary care in a Skilled Nursing Facility or Physical Rehabilitation Facility. Covered services include semi-private room and board and ancillary services commonly billed by a Skilled Nursing Facility or Physical Rehabilitation Facility. Your services must be furnished by a Network Provider, according to

the Referral of your PCP. Benefits are limited to 100 inpatient days per calendar year, per facility. 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. Care is custodial if it can be provided by persons who do not have professional training or skills. Custodial care includes, but is not limited to assisting in activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating, taking medicine and maintaining personal hygiene or safety. Custodial care also includes routine maintenance of ostomies, urinary catheters and tube feedings.

- 3. Outpatient Care.** Benefits are available for approved Covered Services customarily provided in the outpatient department of a Short-term General Hospital. Benefits are also available for Covered Services provided in a licensed ambulatory surgical center, hemodialysis center or birthing center. Your services must be furnished by a Network Provider, according to the Referral of your PCP or your Network Obstetrician/Gynecologist.
- 4. Emergency Room Visits.** Please see Section 3 for information about Emergency Care.

II. Medical Services

- 1. Allergy Testing and Treatment.** Benefits are available for tests and treatments that you receive to determine the nature of allergies and for desensitization treatments ("allergy shots") to alleviate allergies. Covered Services include test and treatment materials. Services must be furnished by your PCP or by a Network Provider, as approved *in advance* by your PCP's Referral.
- 2. Ambulance Services.** Benefits are available for emergency ambulance transportation to a medical facility for emergency care. For example, ambulance transportation to a hospital from an accident scene or due to symptoms of a heart attack is covered. You do not have to obtain your PCP's Referral *in advance* in order to be eligible for Benefits. However, if your PCP and Anthem later determine that the service was not a Medically Necessary emergency transportation, no Benefits will be available. You will be responsible for the full cost of the ambulance services.

Important note: You must obtain Precertification from the Behavioral Health Network (BHN) *before* a planned transport for Behavioral Health Care (Mental Health or Substance Abuse Care). Please see article III for more information.

3. Cardiac Rehabilitation. Benefits are available for outpatient cardiac rehabilitation programs. Services must be furnished by a Network Provider.

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 your condition(s) is diagnosed or one of the program procedures is completed. The program must be completed within six months of the diagnosis or procedure.

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

4. Chiropractic Services. Benefits are available for Covered chiropractic Services. You pay a \$10.00 copayment for each visit. You do not need a referral from your PCP to be eligible for Benefits. However, Covered Services must be furnished by a Network Chiropractor. Otherwise, no benefits are available.

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

- unlimited office visits for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal manipulation.
- medically necessary diagnostic x-rays furnished by a Network Chiropractor.

Limitations and Exclusions. Wellness care is not covered. The exclusions stated in Section 5 apply to the terms of this Benefit. Services listed above are Covered Services only if:

- The service is medically necessary for the treatment of an illness or injury that is diagnosed or suspected by a Network Chiropractor or another physician, and
- chiropractic care is provided in accordance with New Hampshire RSA 316-A:1.

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.

5. Dental Services. Benefits are available for the following services related to dental care. Except for Emergency Care in a hospital emergency room, services must be approved *in advance* by your PCP and furnished by a Network Provider.

- initial emergency treatment within 24 hours of an accidental injury to sound natural teeth. No Benefits are available for dental services furnished after the initial 24-hour period. No Benefits are available if you damage your teeth or appliances as a result of biting or chewing. Please see Section 3 for more information about Emergency Care.
- surgical removal of erupted teeth before radiation therapy for malignant disease.
- Medically Necessary hospital charges (outpatient or inpatient), surgical day care facility charges and administration of general anesthesia by licensed anesthesiologist or anesthesiologist for:
 - **children under the age of 6.** The child's dental condition must be so complex that the dental procedure must be done under general anesthesia *and* must be done in a hospital or surgical day care facility setting. A licensed dentist and the child's PCP must determine *in advance* that anesthesia and hospitalization are Medically Necessary due to the complexity of the child's condition. Anthem must approve the care *in advance*.
 - **Members who have exceptional medical circumstances or a developmental disability.** The medical circumstance or the developmental disability must be one that places the Member at serious risk unless the dental procedure is done under general anesthesia *and* must be done in a hospital or surgical day care facility setting. The Member's PCP and Anthem must approve the services *in advance*.

Call Anthem during business hours at **1-800-531-4450** for authorization of these services.

No Benefits are available for noncovered dental procedures, even if your PCP and Anthem authorize general anesthesia and hospitalization for the procedure.

Except as stated above, no Benefits are available for treatment of cavities; extractions; care of the gums or bones supporting the teeth; treatment of a periodontal abscess; removal of impacted teeth; orthodontia (including braces); false teeth; treatment of temporomandibular joint syndrome (TMJ); orthognathic surgery; or any other dental service. Expenses due to damage to natural teeth and/or appliances as a result of biting or chewing are not eligible for Benefits.

6. Diagnostic Radiological and Laboratory Services. Benefits are available for Medically Necessary radiological (x-ray) and laboratory tests. This includes diagnostic x-rays, laboratory tests, electrocardiograms, diagnostic clinical isotope services and imaging procedures such as ultrasound, CT scan and MRI (Magnetic Resonance Imaging). Services must be approved *in advance* by your PCP or by your Network Obstetrician/Gynecologist and must be furnished by a Network Provider.

7. Durable Medical Equipment, Prosthetic Devices and Medical Supplies. Benefits are available for Medically Necessary durable medical equipment (DME), prosthetic devices and medical supplies. Covered Services must be ordered by your PCP and furnished by a Network Provider.

Covered Services. Durable medical equipment (DME) is medical equipment primarily and customarily used for a medical purpose. DME is not disposable, can withstand repeated use and is appropriate for use in the home. Covered DME is useful only for a specific illness or injury that a physician has diagnosed or suspects. Examples of DME are: crutches, apnea monitors, oxygen equipment, wheelchairs, special hospital type beds or home dialysis equipment. Oxygen humidifiers are covered if prescribed for use in connection with Medically Necessary DME to moisturize oxygen. 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, per year. You pay a \$5 Copayment for each hearing aid. You do not have to obtain your PCP's Referral for covered hearing aids.

Benefits are available for Medically Necessary prosthetic devices. A prosthetic device replaces an absent body part. Prosthetic devices can also replace the function of a permanently impaired body part. Examples of prosthetic devices are: artificial limbs, breast prosthesis, and implanted lenses after cataract surgery. Benefits are available for scalp hair prostheses (wigs) for Members who have suffered permanent hair loss as a result of alopecia areata, alopecia totalis, or as a result of accidental injury. Benefits are limited to one initial scalp hair prosthesis and one replacement every two years.

Benefits are also available for scalp hair prostheses worn for hair loss suffered 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 for alopecia medicamentosa.

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

Scalp hair prostheses are not covered for temporary hair loss except as described above, or for male pattern baldness.

You pay no Copayment, Deductible or Coinsurance for covered scalp hair prostheses.

Benefits are available for Medically Necessary medical supplies. Medical supplies are small, often disposable items used to treat an illness or injury that a physician has diagnosed or suspects. A medical supply must be appropriate for your diagnosis and useful only for a specific illness or injury. Examples of medical supplies are: diabetic and non-diabetic needles and syringes, diabetic supplies, oxygen, ostomy bags and skin bond necessary for colostomy care. Blood glucose monitoring devices are covered for Members who have diabetes. Support stockings are covered for a diagnosis of phlebitis or other circulatory disease. Eyeglasses (frames and/or lenses) or contact lenses are covered under this article only if the lens of your eye has been surgically removed or is congenitally absent. Please see number 20 (below) for information about eyeglasses for routine vision correction.

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 enteral formulas and for food products modified to be low protein for persons with inherited diseases of amino acids and organic acids. Benefits are limited to a total of \$1,800 per member, per year for modified low protein food products. To be eligible for Benefits, your PCP must issue a written order stating that the enteral formula and/or food product is:

- needed to sustain life;
- Medically Necessary; and
- the least restrictive and most cost-effective means for meeting your medical needs.

If you are not capable of ingesting enteral formula orally, benefits are available for enteral pumps and supplies directly related to the use of the enteral pump.

Limitations. In addition to the limitations and exclusions listed in Section 5, the following limitations apply:

- Whether an item is purchased or rented, Benefits are limited to the Maximum Allowable Benefit. Benefits for purchase or rental will not exceed the Maximum Allowable Benefit for the least expensive service that meets your needs. If you rent or purchase equipment and Anthem pays Benefits equal to the Maximum Allowable Benefit for the equipment, no further Benefits will be provided for rental or purchase of that equipment. You do not become the owner of the equipment. Anthem determines ownership.

- If you choose a service that is more costly than is Medically Necessary for your medical condition, Benefits will be limited to the Maximum Allowable Benefit that Anthem would allow for the least expensive service that meets your needs. In this case, you pay the difference between the Maximum Allowable Benefit and the actual charge.

No Benefits are available for:

- air conditioners, air purifiers, dehumidifiers, arch supports, corrective shoes, special clothing except for: gradient pressure support aids for lymphedema or venous disease and clothing necessary to wear a covered device such as mastectomy bras and stump socks. Humidifiers are covered only to the extent stated above in this article. Room/central heating humidifiers, bath seats, bed pans and elevators are not covered. Eyeglasses, contact lenses and hearing aids are covered only as stated above under "Covered Services." Heating pads, hot water bottles, or raised toilet seats are not covered; and
- self-monitoring devices, except for services specified as Covered Services in this Section; and
- dentures, orthodontics, and dental appliances, including such services for the treatment of temporomandibular joint (TMJ) disorders.

8. Early Intervention Services. Benefits are available 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. Physical, speech and occupational therapy visits do not count toward any annual visit limits that may apply to 15 and 18 below. *However, Benefits are limited, as shown on the Cost Sharing Schedule (enclosed with this Certificate).*

9. Hearing Services. Benefits are available for diagnosis and treatment of ear disease or injury. These services must be furnished by your PCP or by a Network Provider, as approved *in advance* by your PCP's Referral.

Benefits are available for one routine hearing exam each year to determine the need for hearing correction. The exam must be furnished by your PCP or by another Network Provider, as approved *in advance* by your PCP's Referral.

Benefits are available for one hearing aid per ear, per year. You pay a \$5 Copayment for each covered hearing aid. You do not have to obtain your PCP's Referral for hearing aids.

No Benefits are available for hearing services or supplies except as stated above.

10. Home Health Agency Services. Benefits are available for Medically Necessary visits by Home Health Agency personnel to your home or other place of residence. The services must be approved *in advance* by your PCP and furnished by a Network Provider.

Covered Home Health Agency Services include the following:

- Medically Necessary part-time or intermittent skilled nursing care by (or under the supervision of) a Registered Nurse;
 - Medically Necessary part-time or intermittent home health aide services that consist primarily of caring for you under the supervision of a Registered Nurse;
 - prenatal and postpartum homemaker visits. Homemaker visits must be Medically Necessary, as determined by your Network Provider and Anthem's case manager. 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;
 - Medically Necessary skilled treatments furnished by licensed Home Health Agency personnel including nonprescription medical supplies and drugs furnished by a Home Health Agency. Nonprescription medical supplies and drugs may include surgical dressings and saline solutions. Prescription drugs, certain intravenous solutions and insulin are not included. Please see article VI for information about prescription drugs.
 - Medically Necessary physical, occupational, or speech therapy furnished by licensed Home Health Agency therapists. Each therapy visit counts toward the limitations described in numbers 15 and 18, (below).
- 11. Infusion Therapy.** Benefits are available for Medically Necessary infusion therapy services. The services must be approved *in advance* by your PCP and furnished by a Network Provider. Covered infusion therapy services are limited to:
- home nursing services for intravenous antibiotic therapy, chemotherapy or parenteral nutrition therapy;
 - antibiotics, chemotherapy agents, medications and solutions used for parenteral nutrients;
 - Medically Necessary associated supplies and portable, stationary or implantable infusion pumps.
- Please see number 7 (above) for information about enteral formula Benefits.

12. Maternity Services. Maternity services must be provided by a Network Obstetrician/Gynecologist or by your PCP or by another physician with a Referral from your PCP. Covered maternity services include any service related to pregnancy and/or delivery. These include, but are not limited to: prenatal care, obstetrical delivery, surgical procedures, hospital care and postpartum care for the mother.

The Benefit for a physician's services related to your pregnancy includes prenatal visits, obstetrical delivery, inpatient medical care and postpartum visits. Although you will receive these services at various times during your pregnancy, the date of service that determines Benefit eligibility is the date of delivery.

Benefits are available for all of the Medically Necessary Covered Services set forth in this Section with respect to pregnancy, tests and surgery related to pregnancy, complications of pregnancy or miscarriage. Ultrasounds are covered only when Medically Necessary.

Benefits are not available for pregnancy or delivery of a baby unless the mother's prenatal care is furnished by her PCP or by a Network Obstetrician/Gynecologist. Also, Benefits are not available for the delivery of a baby when:

- the delivery occurs outside of the Service Area within 30 days of the baby's due date, as established by the mother's obstetrician, and
- the delivery is not authorized according to a Referral and Anthem's Precertification *before the mother leaves the Service Area.*

Please note: Healthy Kids Silver provides Benefits to the enrolled Member only. No coverage is provided under this Certificate for the newborn child of a Member. For information on obtaining coverage for a Member's newborn child, please contact NHHKC at 1-877-464-2447.

13. Medical Care (Office, Home and Hospital Visits). Benefits are available for your visits to your PCP's office or when your PCP visits you at home. Benefits are available for each visit to another Network Physician, as approved *in advance* by your PCP's Referral.

Benefits are available for a physician's visits to you in a hospital (inpatient or outpatient). Hospital visits must be furnished by your PCP or by your Network Obstetrician/Gynecologist or by another Network Provider, as approved *in advance* by your PCP's Referral.

Benefits for inpatient medical care are limited to daily care furnished by the attending physician, unless another Network Physician's services are Medically Necessary, as determined by Anthem.

No Benefits are available under this Certificate for your newborn baby's care. For information on obtaining coverage for a newborn, please contact NHHKC at 1-877-464-2447.

14. Medications and Supplies Dispensed in a Physician's 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. The office visit must be furnished by your PCP or by another Network Provider, as approved *in advance* by your PCP's Referral. No Benefits are available for fertility hormones or fertility drugs.

Benefits for covered hormones, insulin and prescription drugs purchased at a physician's office for use outside the office are not covered under this article. Please see article VI for more information about Benefits for "take-home" prescription drugs. Please see number 7 (above) for information about Benefits for durable medical equipment (DME), prosthetic devices and medical supplies purchased for use outside a physician's office.

15. Physical Therapy and Occupational Therapy. Benefits are available when Covered Services are approved *in advance* by your PCP's Referral and furnished by a Network Physical or Occupational Therapist. You pay a \$5 Copayment for each visit.

Medically Necessary physical and occupational therapy can be furnished in a therapist's office, in the outpatient department of a hospital or in your home by a Home Health Agency. The services must be furnished during the acute care stage of an illness or injury. Physical and occupational therapy is covered for long-term conditions only when an acute episode occurs, such as following surgery. No Benefits are available for therapy furnished beyond the acute care stage of an illness or injury or following surgery. Therapy services must be restorative, with concise, measurable gains and goals. Services must provide significant improvement within a reasonable and generally predictable period of time. No Benefits are available for educational reasons or for developmental disabilities.

16. Preventive Health Services

Benefits are available for the following preventive health services.

- **Diabetes management program.** Benefits are available for individual counseling visits and group education programs for diabetes management. To be eligible for Benefits, you must meet the following terms:
 - Members who have a diagnosis of diabetes
 - You do not need a Referral from your PCP.

Covered Services must be furnished by a Network Diabetes Education Provider. A Network Diabetes Education Provider is a certified, registered or licensed health care expert in diabetes management who has a written agreement with Anthem to furnish diabetes counseling and diabetes education to members. You may call Customer Services for the most recent listing of Network Diabetes Education Providers. Or, you may access our website at anthembcb.com.

Please note: Benefits for insulin pump education may be available when the education is provided by a pump-certified, Network Education Provider. The Network Diabetes Education Provider will obtain prior approval.

Please see number 7 (above) and article VI (below) for information about diabetes supplies, prescription drugs and insulin.

In addition to the exclusions listed in Section 5, the following limitations apply to diabetes management services:

- No Benefits are available for services furnished by a provider who is not a Network Diabetes Education Provider.
- You must meet Anthem's participation requirements for group education in order to be eligible for Benefits. For example, if your group education program consists of a 10-hour schedule, you may be required to participate in at least 8 sessions to be eligible for Benefits. If you do not meet the program participation requirements, you will be responsible for paying the full enrollment cost. The Network Diabetes Education Provider will inform you about program participation requirements.
- 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.
- **Family planning.** Benefits are available for family planning services. Services must be provided by your PCP or by another Network Provider, as approved *in advance* by your PCP's Referral, unless your services are for obstetrical or gynecological care. Obstetrical or gynecological care may be furnished by any Network Obstetrician/Gynecologist without a Referral from your PCP.

Family planning services are limited to routine medical exams, routine diagnostic tests, pregnancy tests, and birth control counseling. Benefits are also available for Depo-Provera injections furnished during a covered office visit.

No Benefits are available for:

- any costs associated with an assisted reproduction technology, artificial inseminations or achieving pregnancy through surrogacy;

- birth control preparations (such as contraceptive creams and foams, condoms, spermicidal jelly and contraceptive sponges);
- Please see article VI, "Prescription Drug Benefits," for other information about purchasing Depo-Provera and for information about federal legend oral contraceptives. Except as stated above and in article VI, no Benefits are available for levonorgestrel implant systems (such as Norplant) or for the insertion or removal of such systems;
- fertility hormones and fertility drugs are not covered under any portion of this Certificate.

- **Routine gynecological exams.** Benefits are available for one routine gynecological exam each year. The exam must be furnished by your PCP or by any Network Obstetrician/Gynecologist.
- **Routine hearing exams.** Benefits are available for one routine hearing exam each year to determine the need for hearing correction. The exam must be furnished by your PCP or by another Network Provider, as approved *in advance* by your PCP's Referral.

- **Routine laboratory and x-ray tests.** Benefits are available for routine laboratory and x-ray tests (such as pap smears and mammograms) that are standard services related to routine office exams. The services must be furnished by your PCP or Network Obstetrician/Gynecologist or by another Network Provider, as approved *in advance* according to a Referral from your PCP or your Network Obstetrician/Gynecologist.

Ultrasounds in pregnancy are covered only when Medically Necessary.

- **Routine medical exams and childhood immunizations for well children.** Benefits are available for routine office exams and childhood immunizations (including travel-related immunizations) for well children. The services must be furnished by your PCP or by another Network Provider, as approved *in advance* by your PCP's Referral. You do not pay an office visit Copayment for routine childhood exams or immunizations.

No Benefits are available for your baby's inpatient newborn care. For information on obtaining coverage for a newborn, please contact NHHKC at **1-877-464-2447**.

- **Routine prenatal care.** Benefits are available for routine prenatal care visits furnished by a Network Obstetrician/Gynecologist. You do not need a PCP Referral for routine prenatal care furnished by a Network Obstetrician/Gynecologist. You do not pay the Office Services Copayment for routine prenatal care visits.

Please see number 12 (above) for more information about Maternity Services.

- **Routine vision care.** Benefits are available for one routine vision exam per calendar year to determine the need for vision correction. You do not have to obtain your PCP's Referral to be eligible for Benefits for *routine* eye exams. However, the exam must be furnished by a Network Optometrist or Network Ophthalmologist.

17. Radiation Therapy and Chemotherapy. Full Benefits are available for radiation therapy, chemotherapy and radiation oncology services. Radiation oncology services may include use of x-rays, radiation, or radioactive isotopes. The services must be furnished by a Network Provider, as approved *in advance* by your PCP's Referral.

18. Speech Therapy. Benefits are available when Covered Services are approved in advance by your PCP's Referral and furnished by a Network Speech Therapist. You pay a \$5 Copayment for each Medically Necessary visit.

Speech therapy can be furnished in a therapist's office, in your home (when furnished by a Home Health Agency) or in the outpatient department of a hospital. The following speech therapy services are covered:

- an evaluation by a licensed speech therapist to determine if speech therapy is Medically Necessary, and
- approved individual speech therapy sessions (including services related to swallowing dysfunctions) by a licensed speech therapist.

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. The therapy must be restorative, with concise, measurable gains and goals. Services must provide significant improvement within a reasonable and generally predictable period of time. Your services must require the direct intervention, skilled knowledge and attendance of a licensed speech therapist.

In addition to the exclusions listed in Section 5, no Benefits are available for voice therapy, vocal retraining, preventive therapy, therapy provided in a group setting or therapy for educational reasons or for developmental disabilities.

19. Surgery. Full Benefits are available for Medically Necessary surgical services (including Medically Necessary surgical assistants and administration of anesthesia for surgery, maternity care and other procedures). The services must be furnished by your PCP or by another Network Provider, as approved *in advance* by your PCP's Referral.

Surgery includes correction of fractures and dislocations, delivery of a baby, endoscopies and any incision or puncture of the skin or tissue which requires the use of surgical instruments. Surgery does not include: inoculation, vaccination, collection of blood or administration or injection of drugs.

Benefits are available for Medically Necessary reconstructive surgical procedures. Reconstructive surgery is any surgical procedure that:

- is made necessary by accidental injury; or
- is necessary to correct birth defects for children who have functional physical deficits due to the birth defect (cosmetic surgery is not covered); or
- is necessary to reconstruct or restore a functional part of the body following a covered surgical procedure for disease or injury; or
- is Medically Necessary to restore or improve a bodily function.
- 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.

Cosmetic procedures are not covered. Cosmetic procedures are procedures primarily intended to change or to improve your appearance or are for your psychological benefit. 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 or shape of your nose, ears, chin, chest or breasts, except for the reasons stated above.

Dental services are covered only as stated in number 5 (above).

If you intend to receive services that may be considered reconstructive, cosmetic or dental, it is suggested that you obtain written approval from Anthem *before* you receive the services. You can request written approval by submitting your physician's written description of the service to:

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

Also, please see article IV, "Organ and Tissue Transplant Procedure Benefits," for information that may be related to your surgical services.

20. Vision Services. Benefits are available for Covered Services for the diagnosis and treatment of eye disease or injury. Services must be furnished by your PCP or by another Network Provider, as approved *in advance* by your PCP's Referral. Covered Services (such as Hospital Care, Medical Care and Diagnostic Laboratory and X-ray services) are described throughout this Section. Also, please see number 7 (above) for information about frames and lenses when the lens of the eye has been removed or is congenitally absent.

Benefits are available for one routine vision exam per calendar year to determine the need for vision correction. You do not have to obtain your PCP's Referral to be eligible for Benefits for *routine* eye exams. However, the exam must be furnished by a Network Optometrist or Network Ophthalmologist.

Benefits are available for one pair of eye glasses (frames and lenses) per calendar year for routine vision correction. The Benefit for eye glasses can include scratch coating. The selection of frames and lenses is limited to the selection available to members of the Healthy Kids Silver program. Otherwise, no benefits are available.

Non-Covered Services include:

- tinted lenses,
- prescription sunglasses,
- repair or replacement of broken lenses or frames, and
- contact lenses.

No Benefits are available for vision services except as stated above. No Benefits are available for eye surgery to correct errors of refraction, such as radial keratotomy and PRK Laser (photo refractive keratectomy).

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

1. Precertification from BHN. The Behavioral Health Network (BHN) is Anthem's designated behavioral health care administrator. You must call BHN for Precertification *before* you receive care for a Mental Disorder or Substance Abuse Condition. You must receive Covered Services from a BHN Network Provider, as approved *in advance* by BHN's Precertification. A BHN Network Provider is a hospital or other eligible provider who has an agreement with BHN to provide Covered Mental disorder and Substance Abuse Care available to Members.

Please call BHN at 1-800-228-5975 for Precertification before you receive Behavioral Health Care.

After you call, BHN will send you a letter (Precertification) that specifies the Covered Services authorized by BHN. BHN's Precertification letter will specify the name of the BHN Network Provider that BHN has approved for your Covered Services. BHN's Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of the Certificate that is in effect on the date you receive Covered Services.

With BHN's Precertification, Benefits are available for the diagnosis, crisis intervention and short-term treatment of acute Mental Disorders and Substance Abuse Conditions. **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 set 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 Certificate.

No Benefits are available if:

- you do not obtain Precertification from BHN *in advance*, or
- your Covered Services exceed the limits of BHN's Precertification, or
- you receive services from an provider other than the BHN Network Provider authorized *in advance* by BHN.

Please note:

- If you are admitted by your physician to a Short-term General Hospital for medical detoxification (without BHN's Precertification), Benefits are available as stated in article I, of this Section, "Inpatient Care in a Short-term General Hospital."
- Behavioral Health Care in a hospital emergency room is not covered under this article. Benefits for emergency room visits are explained in Section 3.
- *Emergency* ambulance transportation to a hospital for Behavioral Health Care is not covered under this article. Please see article II, 2 of this Section, "Ambulance Services." Precertification from BHN is required before *scheduled* ambulance transportation.

2. Covered Services. Benefits are available for the following Covered Services. Services must be furnished by a BHN Network Provider, as approved *in advance* by BHN's Precertification:

- **Outpatient/office visits.** For evaluation, therapy, and counseling for the treatment of substance abuse conditions (including substance abuse detoxification and rehabilitation). Benefits may be limited to a certain number of visits per year, as shown on your Cost Sharing Schedule. Visits for psychological testing and medication checks are covered, but do not count towards the annual limits.
- **inpatient care.** For mental disorders, Benefits are available for up to 15 inpatient days per year. Benefits are available for inpatient substance abuse medical detoxification, as approved in advance by BHN's Precertification. Inpatient substance abuse rehabilitation is covered, subject to the terms of the Substance Abuse Rehabilitation Endorsement in effect on the date of admission. Please see your endorsement for important information about coverage and limitations.
- **partial hospitalization programs.** Benefits are available for partial hospitalization for Mental Disorders. The 15-day inpatient care maximum applies. Two partial hospitalization days count as one full inpatient day toward the 15-day maximum. Benefits are available for partial hospitalization programs (sometimes called "day/evening" programs) for Substance Abuse Conditions. Covered services are subject to the terms and limitations of the Substance Abuse Rehabilitation Endorsement in effect on the date of the service.
- **hospital outpatient services.** Benefits are available for hospital outpatient services, such as diagnostic tests and therapeutic services.
- **scheduled ambulance transportation.** Benefits are available for scheduled transport by ambulance from one facility to another for Behavioral Health Care.

3. Additional Benefits. If you exhaust the annual maximums stated in number 2, additional Benefits are available for Covered Services you receive in treatment of the following mental disorders (as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association):

- schizophrenia and other psychotic disorders such as, but not limited to paranoia
- schizoaffective disorder
- major depressive disorder
- bipolar disorder
- obsessive-compulsive disorder

- panic disorder
- pervasive developmental disorder or autism
- anorexia nervosa
- bulimia nervosa and
- chronic post-traumatic stress disorder

Annual maximums do not apply to the above-listed illnesses. The Precertification rules stated in number 1 (above) apply.

4. Eligible Behavioral Health Care Providers means any of the following:

- **Certified Alcohol and Drug Abuse Counselor** – an individual who has passed the National Certified Exam for Certified Alcohol and Drug Abuse Counselors.
- **Certified Clinical Social Worker** – an individual who is licensed or certified to practice independently as a Clinical Social Worker according to the provisions of law in the state where the individual's 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.
- **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 Therapist must furnish Covered Services as stated in Section 4, article III. Marriage and Family counseling is not covered under this Certificate.
- **Partial Hospitalization Program** – means an intensive nonresidential psychiatric program designed to reduce or eliminate the need for an inpatient admission for a Mental Disorder. The program must provide a multidisciplinary structured therapeutic treatment program under the direction of an eligible Psychiatrist or Psychologist. The program must operate five days per week and for no less than six hours per day.
- **Pastoral Counselor** – a professional who is certified under New Hampshire Statute RSA 330-A:16-C 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 which provides diagnostic services, treatment and care of acute Mental Disorders under the care of a staff of physicians. A Private or Public Hospital must provide 24-hour nursing service by or under the supervision of a Registered Nurse (R.N.) and must keep permanent medical history records.
- **Psychiatrist** – a professional who is a licensed physician and is Board Certified or Board Eligible according to the regulations of the American Board of Psychiatry and Neurology.
- **Psychiatric Advanced Registered Nurse Practitioner** – a professional who is licensed as a registered nurse in advanced practice by the State of New Hampshire or licensed in accordance with the provisions of the laws of the state in which they practice and who is certified as a clinical specialist in psychiatric and mental health nursing.
- **Psychologist** – a professional who is certified under New Hampshire Statute RSA 330-A, or under a similar statute in another state, which meets or exceeds the standards under RSA 330-A 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.

Note: Benefits as described in this Certificate are provided for authorized Covered Services by providers located outside New Hampshire only when the provider is licensed according to state requirements that are substantially similar to those required by Anthem and BHN. Also, the provider must meet the educational and clinical standards that Anthem and BHN require for health care provider eligibility.

- 5. Criteria for Coverage.** Covered Services must meet the following criteria:
- Benefits are limited to short-term therapy during the acute stage of a Mental Disorder or Substance Abuse Condition. The disorder or condition must be shown to affect the Member's ability to perform daily activities at work, at home, or at school. Services must focus on acute symptoms, be solution-focused and goal-oriented and must demonstrate

ongoing improvement in a Member's condition or level of functioning. Benefits are available for periodic treatment of a chronic disorder or condition to prevent deterioration of function.

- Services must be provided at the level of care that is most appropriate for addressing the severity of the Member's disorder 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 Mental Health or Substance Abuse Provider furnishing the care.
- Services must be in keeping with national standards of mental disorder and substance abuse professional practice, as reflected by scientific and peer specialty literature.

Please see Section 3 for information about Emergency Services.

6. Exclusions. In addition to the exclusions listed in Section 5, the following limitations apply to behavioral health care (mental health and substance abuse care):

- services extending beyond the period necessary for diagnosing and evaluating any Mental Disorder which, according to generally accepted professional standards, is not subject to favorable modification through short-term therapy. Such disorders include, but are not limited to, mental retardation and developmental disabilities.
- duplication of services (the same services provided by more than one therapist during the same period of time),
- treatment of obesity or weight control programs or services,
- custodial care, convalescent care, milieu therapy, marriage or couples counseling, therapy for sexual dysfunctions, recreational or play therapy, educational evaluation or career counseling,
- services for nicotine withdrawal or nicotine dependence,
- psychoanalysis,
- confinement or supervision of confinement that is primarily due to adverse socioeconomic conditions, placement services and conservatorship proceedings,
- missed appointments,
- telephone therapy or any other therapy or consultation that is not "face-to-face" interaction between the patient and the provider.

7. Appeal Procedure. Please see Section 9.

IV. Organ and Tissue Transplant Services

Benefits are available for the Covered Services described in this article. The services must be approved *in advance* by your PCP's Referral. You and the organ donor must receive services from a Network Provider, Contracting Provider or other Designated Provider, as determined by Anthem.

You must meet all of the criteria for transplant eligibility as determined by Anthem and by the Provider. The transplant must be generally considered to be the treatment of choice by Anthem and by the Provider.

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.

Covered Transplants. The following organ transplants are covered if all of the conditions stated in this article 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 as required by law;
- 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 age 16 or less with short bowel syndrome when there is irreversible intestinal failure, an established TPN (total parenteral nutrition) dependence for a minimum of two years, or there is evidence of severe complications from TPN. No Benefits are available for isolated small bowel transplants in adults. Simultaneous small bowel/liver transplants are covered for children and adults with short bowel syndrome when there is irreversible intestinal failure, an established TPN dependence for a minimum of two years, evidence of severe complications from TPN or evidence of impending end-stage liver failure.

Hospital Care for Transplant Services. Benefits are available for approved Hospital Care for Covered Transplant Services. Covered Hospital Care is described in article I of this Section.

Medical/Surgical Services. Benefits are available for approved inpatient and outpatient medical/surgical services related to Covered Transplant Services. Such services are described throughout this Section.

Organ Procurement. Full 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 an approved Covered Transplant Service. Benefits are available only to the extent that the costs are not covered by other insurance.

Limitations. No Benefits are available for any organ transplant procedure that is not specifically stated to be a Covered Service under this Article. Experimental transplant procedures and procedures that are not Medically Necessary are not covered. No Benefits are available for transplants using artificial parts or non-human donors. 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 transportation and/or lodging costs of a transplant recipient, an organ or tissue donor or for individuals traveling with the recipient or donor. In addition to the limitations and exclusions stated in this Section, the Exclusions listed in Section 5 apply to Transplant Services.

V. Hospice Services

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 your PCP's Referral and must be furnished by a Network Hospice Provider;
- care must be approved *in advance* according to Anthem's Precertification;
- your physician must issue a prognosis of approximately six months life expectancy or less, based on expected disease progression. You or your 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;
- You (or your legal guardian), your physician and your medical team must support hospice care because it is in your 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 your care. The primary care giver does not need to live in your home.

Anthem and your Network Hospice Provider will establish an individual hospice plan that meets your individual needs. Each portion of an individual hospice plan must be Medically Necessary, as approved *in advance* by Anthem's Precertification. Examples of Covered Services that may comprise an individual hospice plan include (but are not limited to):

- skilled nursing visits,
- physical therapy for comfort measures, and
- home health aide services.

No Benefits are available for hospice services that exceed the limits of your PCP's Referral or Anthem's Precertification.

VI. Prescription Drug Benefits

I. Introductory. Benefits are available for Covered Services that you purchase at a retail Pharmacy. Please refer to your Network Directory for a listing of New Hampshire Network Pharmacies.

Anthem's list of covered prescription drugs is called "formulary list". This list is subject to change. Benefits are limited to the drugs and treatments included in the formulary list. Covered Services are added and deleted from the formulary list by Anthem's Pharmacy and Therapeutics Committee.

You may review a copy of the current formulary on our website at: www.anthemprescription.com. You may also request a copy of the formulary by calling a customer service representative at the number of the back of your ID card. The formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the formulary is not a guarantee of coverage. Please see articles IV and V (below) for information on limitations and exclusions.

Services must be purchased at a licensed pharmacy. In general, your out-of-pocket cost are less if you purchase Covered Services at a Network Pharmacy. A Network Pharmacy is a pharmacy that has a written agreement with Anthem to provide Covered Prescription Drug Services to Members. Network Pharmacies accept Anthem's Maximum Allowable Benefit as payment in full for Covered Services.

If you purchase services at an Out-of-Network Pharmacy or if you do not show your identification card at a Network Pharmacy, you will be required to pay the full cost of the prescription. To obtain reimbursement, you will need to complete a claim form and submit it as directed on the form. Reimbursement is limited to the Maximum Allowable Benefit, minus your cost sharing amount.

II. Covered Services. The following prescriptions are covered.

A. Prescription Legend Drugs. A Prescription Legend Drug can be dispensed only pursuant to a prescription order, under federal or state law.

B. Prescribed insulin and oral diabetes medications.

C. Prescribed diabetic supplies (such as blood glucose test strips, lancets, and diabetic needles and syringes for diabetic Members. Basic blood glucose monitors are also covered for diabetic Members. Any cost exceeding the Maximum Allowable Benefit for a basic blood glucose monitor is not covered. For example, cost for convenience features (such as features that download information to a computer or special portability features) are not covered.

D. Contraceptive drugs, such as oral contraceptives and Depo-Provera.

E. Vitamins that require a prescription by law

F. Human growth hormones. Benefits are available to treat children with short stature who have an absolute deficiency in natural growth hormone. Benefits are also available to treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.

Please note: Human growth hormones must be authorized *in advance* by your child's PCP and must be precertified by Anthem. Please call 1-800-531-4450 for Precertification of human growth hormones.

III. Cost Sharing

You pay one Copayment for each prescription filled.

Whenever possible, a generic drug will be dispensed.

- You pay a \$5 Copayment for a generic drug purchased at a network retail pharmacy.
- You pay a \$10 Copayment for a brand name drug purchased at a network retail pharmacy. The following exceptions apply:
 - If there is no generic substitute for the brand name drug, you pay the \$5 generic Copayment, and
 - If the prescribing physician indicates that a generic substitute is not medically appropriate, you pay the \$5 generic Copayment.
- You pay a \$5 Copayment for each prescription filled through the mail service program.

IV. Limitations. The following limitations apply to Covered Services:

A. Prescriptions may be filled up to a 30-day supply; or up to Anthem's dispensing limitation; or, as regulated by law; or as ordered by your physician, whichever is less. Exception to the 30-day limit are:

B. Prescriptions for Depo-Provera are filled up to the life-expectancy of the drug.

C. Prescriptions for basic blood glucose monitors are filled up to the monitor's life-expectancy.

D. Prescriptions for other diabetic supplies are filled according to your physician's prescription order.

E. "maintenance medications" may be filled up to a 90-day supply through the mail service program. Maintenance medications are prescription drugs taken for certain conditions that require long term medication. Anthem maintains a list of maintenance medications. This list is subject to change.

"Controlled substances" are not considered "maintenance medications". Laws regulates supplies of controlled substances. Controlled substances cannot be purchased from the mail service pharmacy.

V. Exclusions. In addition to the limitations listed above and in Section 5 of this Certificate, no Benefits are available for the following:

A. Prescriptions filled for home use in any setting other than prescriptions taken by or administered to a Member in any Outpatient setting (except as stated in this section); prescriptions taken by or administered to a Member who is a patient in a licensed hospital, nursing home, sanitarium or similar institution, or charges for such administration.

B. Appetite suppressants, anorectics, or any drug used for the purpose of weight management.

C. Vaccines, toxoids, biologicals, blood or blood plasma, plasma expanders or proteins.

D. Cosmetic agents or medications used for cosmetic purposes.

E. Experimental or Investigational prescriptions that have not been approved for any indication by the Food and Drug Administration (FDA).

Benefits are available for drugs or devices that are provided to you during your participation in a clinical trial, as required by NH RSA 415:18-l, subject to the terms and conditions of this rider.

No Benefits are available for prescriptions (including drugs or devices) that are the subject of a clinical trial.

F. Prescriptions that are not approved by the FDA for clinical use.

G. Prescriptions that are approved by the FDA for clinical use but have not been available in the marketplace for six months after such approval.

During this six-month period your physician may request authorization from Anthem for an exception for coverage.

Your physician must provide supporting clinical rationale for the exception. Anthem will respond to your physician within 48 hours of receipt of the supporting clinical rationale.

If the exception is authorized, Benefits will be provided according to the non-Formulary Copayment (if applicable), and this authorization does not modify the Formulary.

The appeal procedure outlined in Section 9 of this Certificate is available if you disagree with Anthem's decision.

H. A drug prescribed for off-label use if the FDA has determined its use to be contraindicated for the prescribed use.

Benefits are available for drugs prescribed for off-label use if recognized for treatment of the indication in one of the standard reference compendia; or in the medical literature, as recommended by current American Medical Association policies.

I. Nonlegend (over-the-counter) prescriptions, including:

- prescriptions for which there is an over-the-counter equivalent in both strength and dosage form,
- vitamins or other dietary substances that do not require a prescription by law,
- supplies that can be used for nonmedical purposes, such as alcohol or alcohol wipes, and
- homeopathic products or herbal remedies.

J. Smoking cessation prescriptions.

K. Replacement prescriptions resulting from loss, theft, or damage.

L. Compounded Prescription Legend Drugs without ingredients requiring a prescription order.

M. Therapeutic devices or appliances, support garments and nonmedical substances regardless of intended use, including nondiabetic needles and syringes.

Please see Section 4, number 7 of this Certificate for information about coverage for some of these items.

N. Prescription refills that exceed the physician's orders, or refills dispensed after one year from the physician's original order.

O. Any prescription that is not Medically Necessary, as determined by Anthem.

P. Certain prescription drugs (or the prescribed quantity of a particular drug) that may require prior authorization of benefits.

If you do not receive prior authorization for a prescription that requires prior authorization, your physician may request a review of Anthem's decision. Your physician must provide supporting clinical rationale for Anthem's review. Anthem will respond to your physician within 48 hours of receipt of the supporting clinical rationale.

For information about current drugs requiring prior authorization, please contact a Customer Service representative at the number on your ID card or consult APM's website at: www.anthemprescription.com. The

Formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the Formulary is not a guarantee of coverage. Refer to articles II, IV and V (above) for information on coverage, limitations and exclusions.

You have the right to appeal through the appeals process outlined in Section 9 "Member Satisfaction Services and Appeal Procedure" of this Certificate.

Q. Fertility hormones and fertility drugs.

R. Drugs used for the treatment of impotency and sexual dysfunction.

Exclusions

Section 5

Please see Section 11 for definitions of specially capitalized words.

Benefits are not available for the following items or services under this Certificate.

- 1. Abortion.** Abortion services are not covered.
- 2. Alternative Medicines.** No Benefits are available for alternative medicines, as determined by Anthem's Medical Director. Alternative medicines are protocols or therapies where the clinical effectiveness of such services has not been proven or established. Services in this category include, but are not limited to acupuncture, homeopathy, hypnosis, massage therapy and naturopathy.
- 3. Amounts That Exceed Annual Maximums.** No Benefits are available for any service, supply or treatment that exceeds an annual maximum that is described in this Certificate.
- 4. Amounts That Exceed the Maximum Allowable Benefit (MAB).** Benefits for Covered Services are limited to the Maximum Allowable Benefit (MAB). Anthem determines the Maximum Allowable Benefit for services furnished in New Hampshire. Anthem also determines the Maximum Allowable Benefit for authorized, Covered Services that are furnished by a Nonparticipating Provider outside New Hampshire. If you receive authorized Covered Services from a Participating Provider outside New Hampshire, the Maximum Allowable Benefit is determined by the Blue Cross and Blue Shield Plan in the state where you received the services.
- 5. Artificial Insemination.** No Benefits are available for any type of artificial insemination or assisted reproduction technology. Artificial insemination is

insemination by any method other than natural sexual intercourse. Examples of noncovered services are: in vitro fertilization (test tube), GIFT (Gamete Intra-Fallopian Transfer) or ZIFT (Zygote intra fallopian Transfer). Benefits are not available for any services associated with such noncovered procedures.

- 6. Biofeedback Services.** Biofeedback services are not covered.
- 7. 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.
- 8. 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.
- 9. Care Received When You Are Not Covered Under This Certificate.** Benefits are not available:
 - for any part of your admission if you are confined to a hospital or other institution before the effective date of your coverage under this Certificate.
 - for any inpatient days that occur after the termination date of your coverage under this Certificate.
 - for any other service that you receive before the effective date or after the termination date of your coverage under this Certificate.

- 10. 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.
- 11. Contraceptive Devices, Supplies or Drugs.** No Benefits are available for contraceptive supplies such as (but not limited to) contraceptive creams and foams, condoms, spermicidal jelly or contraceptive sponges. Except as stated in Section 4, articles II and VI, no Benefits are available for contraceptive drugs, devices or supplies or for the insertion or removal of contraceptive drugs, devices or supplies.
- 12. Cosmetic Services.** Cosmetic procedures are primarily intended to change your appearance, to improve your appearance or are furnished for psychological reasons. No Benefits are available for any procedures, services, equipment or supplies provided in connection with cosmetic procedures. Injection of sclerosing solution for varicose veins is not covered. Reconstructive surgery is covered only as stated in Section 4, article II.
- 13. Custodial Care.** No Benefits are available for hospital care, Skilled Nursing Facility care, home care or any other service that is custodial care. Custodial care is primarily for the purpose of meeting personal daily living needs. Care is custodial if it can be provided by persons who do not have professional training or skills. Custodial care includes, but is not limited to assisting in activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating, taking medicine and maintaining personal hygiene or safety. Custodial care also includes routine maintenance of ostomies, urinary catheters and tube feedings.
- 14. Disease or Injury Sustained as a Result of War or Participation in Riot or Civil Disobedience.** No Benefits are available for care required to diagnose or treat any illness or injury that is a result of war, participation in a riot or other act of civil disobedience. Benefits are not available for illness or injury when the cause of the illness or injury was a Member's commission of any illegal activity.
- 15. Educational Programs, Instructional Programs and Developmental Disability Services.** No Benefits are available for educational or instructional programs, except for those programs specifically approved by Anthem under the terms of this Certificate. Please see Section 4, article II. Noncovered programs include, but are not limited to vocational and educational training or testing. No Benefits are available for examinations, evaluations, programs, therapies or services related to educational, behavioral or developmental disabilities or purposes. Except for Covered Services intended to diagnose developmental disabilities, no Benefits are available for pro-

grams, therapies, counseling, or any other service for developmental disabilities. Developmental disabilities are chronic mental or physical impairments which 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.

- 16. Equipment, Devices, Materials, Supplies and Convenience Items.** Except as specified in Section 4, no Benefits are available for the cost of durable medical equipment (DME), prosthetic devices or medical supplies.

No Benefits are available under any portion of your Certificate, riders or endorsements for items which are primarily for your convenience. Convenience items are things that are not directly related to the provision of Covered Services, such as telephone and television rental charges in a hospital. No Benefits are available for air conditioners, humidifiers, dehumidifiers, air purifiers, commodes, exercise equipment, breast pumps, non-prescription supplies, bed pans, heating pads, hot water bottles. Wigs, except as required by law, are not covered. First aid supplies are not covered.

- 17. Experimental/Investigational Procedures, Clinical Trials and Related Equipment and Supplies.** Anthem will not pay for services or supplies which Anthem determines in its sole discretion, are Experimental/Investigational in nature or for the covered services related to such Experimental/Investigational services. Anthem will have authority to determine all questions in connection with whether the use of any drug, biologic, diagnostic, product, treatment, procedure, facility, equipment, device or supply (each of which is hereafter called a "service") is Experimental/Investigational, as follows. No Benefits are available for services related to such Experimental/Investigational services, except for routine patient care costs related to certain drugs and devices that are the subject of clinical trials, as stated in 2 (below). Please see Section 4, VI "Prescription Drug Benefits" for exceptions to this exclusion.

1. Experimental or Investigational means: any service which Anthem determines in its sole discretion to be Experimental or investigational.

- a. Anthem will deem any service to be Experimental or Investigational if it is determined that one of more of the following criteria apply when the service is rendered with respect to the use for which Benefits are sought:

- 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
 - has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service; or
- is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function; or
 - Benefits may be limited to a certain number of visits per year, as shown on your Cost Sharing Schedule is provided pursuant to informed consent documents that describe the service as experimental or investigational or otherwise indicate that the safety, toxicity, or efficacy of the service is under evaluation.
- b.** Any Service not deemed Experimental or Investigational based on the above criteria may still be deemed to be Experimental or Investigational by Anthem. In determining whether a service is Experimental or Investigational, Anthem BCBS will consider the information described in subsection c and assess the following:
- whether the scientific evidence is conclusory concerning the effect of the service on health outcomes;
 - whether the evidence demonstrates 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;
 - whether the evidence demonstrates 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
 - whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- c.** The information considered or evaluated by Anthem to determine whether a service is Experimental or Investigational under subsections (1) and (2) 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 service; 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 service; 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 service; or
 - medical records; or
 - the opinions of consulting providers and other experts in the field.
- Anthem has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.
- 2. Routine Patient Care Related to Clinical Trials.** Benefits are available for Medically Necessary *routine patient care related to* drugs and devices that are the subject of clinical trials, provided that all of the following terms and conditions are met:
- a.** The drug or device under study must be approved for sale by the FDA (regardless of indication).
- b.** The drug or device under study must be for cancer or any other life-threatening condition.
- c.** The drug or device must be the subject of a clinical trial approved by one of the following:
- a National Institutes of Health (NIH),
 - an NIH cooperative group or an NIH center,
 - the FDA (in the form of an investigational new drug application or exemption)
 - the federal department of Veterans Affairs or Defense, or
 - An institutional review board of an institution in NH that has a multiple assurance contract approved by the Office of Protection from Research Risks of the NIH.

- d. Standard treatment has been or would be ineffective, does not exist or there is no superior non-Investigational treatment alternative.
- e. 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.
- f. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-Investigational alternative.
- g. For phase III or IV clinical trials (clinical trials involving leading therapeutic or diagnostic alternatives) Benefits are available for routine patient care, provided that all of the conditions stated in this article are met and subject to all of the other terms and conditions of this Certificate.

For phase I or II clinical trials (clinical trials involving emerging technologies), Benefits are available for routine patient care only if:

- all of the conditions stated in this article are met and subject to all of the other terms and conditions of this Certificate, and
- Anthem reviews all of the information available regarding your individual participation in a Phase I or II clinical trial and determines at its sole discretion that Benefits will be provided for your routine patient care.

Otherwise, no Benefits are available for routine patient care related to phase I or II clinical trials.

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

Routine patient care *does not include*:

- the drug or device that the trial is testing,
- Experimental or Investigational drugs or devices not approved for market for any indication by the FDA,

- non-health care services that a Member may be required to receive in connection with the clinical trial or services that are provided to you for no charge,
- services that are clearly inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, as determined by Anthem.
- the cost of managing the research associated with the 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 determined by Anthem,
- any service not specifically stated as a Covered Service or subject to an exclusion or limitation in this Certificate are not routine patient care.

Please note: Prescription drugs may also be routine patient care. Please see Section 4, VI "Prescription Drug Benefits" for information.

18. Food and Food Supplements. Except as required by applicable law, no Benefits are available for foods, food supplements or for vitamins.

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

20. 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 had been furnished to you without charge if you were not covered under this Certificate or under any other health benefit plan or other insurance.

21. Government Programs. Except as indicated in this Certificate for New Hampshire Healthy Kids, Benefits are not provided for Covered Services to the extent that Benefits for such services are payable under Medicare or any other federal, state or local government program.

22. Home Test Kits. No Benefits are available for laboratory test kits for home use. These include, but are not limited to, home pregnancy tests, home HIV tests and home test kits to detect drug use. This exclusion does not apply to blood glucose monitoring devices, diabetic supplies or any other Covered Service described in Section 4 for home use.

23. Hospitalization for Noncovered Services. No Benefits are available for hospital services related to noncovered procedures.

24. Infertility Services. No Benefits are available for services furnished to diagnose or to confirm a diagnosis of infertility. No Benefits are available for the treatment of infertility, such as:

- surgical procedures to correct medical conditions contributing to infertility,
- any assisted reproduction technology, in-vitro fertilization, artificial insemination or for any service related to such services,
- sonograms (ultrasounds), laboratory services, radiological services or any other service related to a fertility or reproduction procedure,
- any service related to achieving pregnancy through surrogacy,
- reversal of voluntary sterilization,
- infertility treatment needed as a result of a prior sterilization (or sterilization reversal) procedure,
- supplies (such as thermometers and kits to predict ovulation).

Fertility hormones and fertility drugs are not covered under any portion of this Certificate.

25. Maternity Services. Please see Section 4, article II, for important limitations about maternity services.

26. 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.

27. Newborn Care. Healthy Kids Silver provides Benefits to the enrolled Member only. No coverage is provided under this Certificate for the newborn child of a Member. For information on obtaining coverage for a Member's newborn child, please **contact NHHKC at 1-877-464-2447.**

28. Non-Hospital Institutions. 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.

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

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

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

32. Private Room. If you occupy a private room, you will have to pay the difference between the hospital's charges for private room and the hospital's most common charge for a semi-private room, unless it is Medically Necessary for you to occupy a private room. Your PCP must provide us with a written statement regarding the Medical Necessity of your use of a private room, and Anthem must agree *in advance* that private room accommodations are Medically Necessary.

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

34. Rehabilitation Services. Except as stated under the terms of the Substance Abuse Rehabilitation Endorsement, 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 or for pulmonary rehabilitation programs.

35. Required Examinations. No Benefits are available for examinations or services that are ordered by a third party and are not Medically Necessary to treat an illness or injury that your physician finds or reasonably suspects. No Benefits are available for examinations or services 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 Section 4. Court ordered examinations or services are covered, provided that:

- the services are Medically Necessary Covered Services furnished by an Eligible Provider or a Designated Provider, and
- all of the terms and conditions of this Certificate are met.

36. 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 sterilization (or sterilization reversal) procedure.

37. Routine Care or Elective Care Outside the Service Area. Benefits are not available for routine care outside the Service Area. Routine care includes, but is not limited to: routine medical examinations, routine gynecological examinations, diagnostic tests related to routine care, immunizations or other preventive care. Benefits are not available for Elective Care out-

side the Service Area. Elective Care is care that can be delayed until you return to the Service Area. Examples of Elective Care include, but are not limited to: inpatient admissions to a hospital, skilled nursing facility or physical rehabilitation facility and outpatient care at a hospital outside the Service Area. To be eligible for Benefits, Out-of-Network care must be authorized *in advance* according to your PCP's Referral and Anthem's Precertification. Otherwise, no Benefits are available.

- 38. Services Not Specified as Covered.** No Benefits are available for services that are not specifically described in Section Four of this Certificate. Such noncovered services include, but are not limited to the following:
- expenses incurred for treatment or services received when you were not enrolled under this health care plan,
 - services received by someone other than the patient, except as stated in Section 4, article IV,
 - a separate fee for services furnished by interns, residents, fellows or other physicians who are salaried employees of the 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,
 - care furnished to a Member's newborn child,
 - fees, postage, taxes or other charges for the shipping or handling of covered equipment or services.

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

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

41. Surrogate Parenting. Costs associated with surrogate parenting are not covered.

42. Transportation. No Benefits are available for transportation costs, except as described in Section 4.

43. Unnecessary Hospital Stays. 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, Anthem or by BHN.

44. Weight Control Services. Except as stated in Section 4, article II, no Benefits are available for any service, care, surgical procedure or program for weight control, weight loss or for control of obesity or morbid obesity even if the weight or obesity aggravates another condition.

45. Wigs. No Benefits are available for hair prostheses (wigs) except as stated in Section 4, article II.

46. Workers' Compensation. We do 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.

47. X-rays. No Benefits are available for diagnostic x-rays in connection with research or study, or fluoroscopy without film.

Coordination of Benefits

Section 6

Please see Section 11 for definitions of specially capitalized words.

I. If the Member is covered under this Certificate and another health care benefits plan, and services are received that are covered by both plans; Benefits will be coordinated

The Coordination of Benefits (COB) rules determine which health care Benefits plan becomes:

- Primary-responsible for applying its Benefits to the reimbursement of services first; or
- Secondary-responsible for applying its Benefits to the reimbursement of services after the application of the primary Benefits.

Note: Healthy Kids Silver is always secondary to any other Health Care Benefits Plan.

II. For purposes of this Section only, “Health Care Benefits Plan” means any of the following, which provide Benefits of services for, or by reason of, medical care or treatment:

- A.** Coverage under government programs, including Medicare and Medicaid, required or provided by any statute in accordance with the limitations of law.
- B.** Any group health insurance policy, contract or other arrangement, including, but not limited to, automobile (no fault and/or medical payments) insurance coverage, where a health Benefit is to be provided, arranged or paid for, on an insured or uninsured basis; and any coverage for students which is sponsored by, or provided through a school or other educational institution above the high school level. The term “Health Care Benefits Plan” will be interpreted separately with respect to:
- Each policy, contract other arrangement for Benefits or services; or
 - That portion of any such policy, contract or other arrangement which reserves the right to take the Benefits of the other Health Care Benefits Plans into consideration in determining its Benefits, and that portion which does not take such Benefits into consideration.

III. For purposes of this Section only, “Allowable Expense” means a Medically Necessary Covered Service, except for the following limitations:

- When benefits are reduced under a primary plan because a Member does not comply with the primary plan’s provisions (such as, but not limited to, managed care provisions), the amount of such reduction is not an Allowable Expense.
- When the primary policy has provided full benefits and there is no Member responsibility, Anthem (as the secondary policy) will not consider any portion of the claim to be an Allowable Expense. “Allowable Expense” means a Medically Necessary Covered Service, except for the following limitations:

IV. Anthem has the right to coordinate Benefits between this Certificate and any other Health Care Benefits Plan covering a Member

If this happens, reimbursement under the two or more plans will not exceed 100 percent of the actual Allowable Expenses incurred by the Member.

One plan (the primary plan) will pay its full Benefits. The other plan (the secondary plan) may pay any Allowable Expenses in excess of the primary plan Benefits, up to the maximum amount that it would pay if the Coordination of Benefits provision was not in force.

When this plan is the secondary plan, Anthem will provide Benefits in conjunction with the primary plan so that the two plans will pay up to the allowable expenses incurred by the patient. The combined payments of both plans will never exceed what Anthem would have paid as the primary plan. The determination of what Anthem would have paid as the primary plan will be based on whether all requirements were met as described throughout this Certificate.

V. Payments to Other Health Benefits Programs

Anthem may repay to any other Health Care Benefits Plan the amount which we paid for Covered Services and which Anthem decides we should have paid. These payments are the same as Benefits paid and they satisfy our obligation to a Member under this Certificate.

VI. Subrogation

If you are injured or suffer an impairment or medical condition that is the result of another party's actions, and we pay Benefits to treat such injury or condition, we will be subrogated to your recovery rights. We are entitled to reimbursement from the responsible party or any other party you receive payment from to the extent of Benefits provided. Our subrogation right includes, but is not limited to underinsured or uninsured motorists' coverage. We may proceed in your name against the responsible party. By accepting this Certificate, you agree to cooperate with us and do whatever is necessary to secure our right and do nothing to prejudice these rights. We reserve the right to compromise the amount of our claim if in our opinion it is appropriate to do so.

VII. Our Rights to Recover Overpayment

In some cases, Anthem may have made payment mistakenly, such as, where a Member had coverage under another Health Care Benefits Plan. Under these circumstances it will be necessary for the Member to refund to Anthem the amount of the mistaken payment.

Anthem also has the right to recover the mistaken payment from the other Health Care Benefits plan if we have not already received payment from that other program. You agree to take such further actions, to execute, deliver, and file such further documents which Anthem requires to help us recover an overpayment or mistaken payment. In accordance with, and to the extent permitted by applicable law, Anthem may reduce our future payments to the Member in order to recover a mistaken payment.

IF YOU HAVE ANY QUESTIONS ABOUT COORDINATION OF BENEFITS, PLEASE CALL ANTHEM DURING BUSINESS HOURS AT 1-800-870-3057.

Membership Eligibility and Termination of Coverage

Section 7

Please see Section 11 for definitions of specially capitalized words.

Note: “you” means the covered child.

I. Who Is Covered Under This Certificate

To be eligible for coverage under this Certificate, the following criteria must be met:

- you must be at least one year old, but less than 19 years old, and
- you cannot be eligible for public health programs including Medicaid and Medicare, and
- with certain exceptions (as determined by the New Hampshire Healthy Kids Corporation), you cannot have been enrolled in a health plan for at least six months prior to the effective date of this Certificate.

When Coverage Begins. Your coverage begins on the effective date as determined by the New Hampshire Healthy Kids Corporation.

Persons not eligible for membership.

- Children who do not meet the eligibility criteria listed in this Section.
- Children who were previously enrolled in Healthy Kids or Healthy Kids Silver whose coverage lapsed due to nonpayment of premium. Upon the first instance of cancellation for nonpayment of premium, the child will be eligible to reenroll no sooner than three months following the cancellation date.

Notification. A condition of membership is your agreement to notify New Hampshire Healthy Kids Corporation in writing immediately of any changes in address or any changes in status which would affect your eligibility. This includes changes in family income, family size, enrollment in public health programs, and/or if you obtain other insurance coverage.

Disclosure of Coverage. Another condition of membership is your agreement to provide information regarding all other health coverage(s) under which you may be entitled to Benefits.

II. Termination of This Certificate

Subject to the provisions of this Section, your coverage under this plan will terminate in certain circumstances. These circumstances are described below.

Coverage under this Certificate is provided according to the terms of a contract between Anthem and the New Hampshire Healthy Kids Corporation (NHHKC). The NHHKC contract is effective for a fixed term and may be renewed by Anthem and NHHKC. Upon termination of the NHHKC contract, Anthem will no longer provide any Benefits to covered Members.

Default in Payment of Premiums. If the NHHKC does not receive payment on time, coverage under this Certificate will terminate on a date stated in a notice to be mailed by Anthem to the Member.

If You Are No Longer a Member of the NHHKC program. The NHHKC will determine the date that your coverage ends if you become ineligible to participate in this program.

When You Become Eligible for Medicare. If you believe that you may be eligible for Medicare coverage, you should notify the NHHKC immediately. If Medicare becomes your primary coverage, you will have no further coverage under this program.

Our Option to Terminate this Certificate. Anthem may terminate this Certificate for one of the following reasons:

- Coverage will end on the last day of the month when you turn 19 years old, or
- if you are over the age of 18 and you are a high school student, coverage will end on the last day of the month you turn 21 years old.
- Each Member represents that all statements made to the New Hampshire Healthy Kids Corporation, the State of New Hampshire and/or to Anthem for the purposes of obtaining membership are true. If membership is based on any misleading, deceptive, incomplete, or untrue statement which is material to enrollment eligibility, Anthem may void enrollment.
- Anthem may terminate a Member's coverage for fraud committed by the Member (or by the Member's authorized representative) connection with any claim filed under this Certificate.
- Anthem may terminate this coverage following 30 days advance written notice if an unauthorized person uses a Member's identification card with the knowledge and cooperation of the Member or the Member's authorized representative.

Claims Procedure

Section 8

Please see Section 11 for definitions of specially capitalized words.

This Section explains Anthem' Claim Procedure.

I. Post-Service Claims

Are claims for services that you have received and for which no Precertification review is required under the terms of this Certificate. 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*
- under the terms of an agreement with Anthem, the provider can bill you for amounts exceeding your Copayment, Deductible and/or Coinsurance.

Time Limit for Submitting Post-Service Claims. In order for Anthem to 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 authorized services are furnished by an Out-of-Network Provider, you may need to submit your own claim form. Please contact New Hampshire Healthy Kids Corporation or Anthem to obtain the correct claim form as prescribed by Anthem for submission. Our 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.

II. Pre-Service Claims

Certain services are covered in part or in whole only if you obtain Precertification from Anthem or BHN. Please see Section 2 for a complete description of Benefit reductions that may occur if you do not obtain Precertification as required. Other Precertification requirements may be stated in riders or endorsements that amend this Certificate. **Requests for Precertification pursuant to the terms of this Certificate or any amendment to this Certificate are Pre-Service Claims.**

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 and BHN 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.

Time Limit for Submitting Pre-Service Claims. Unless it is not reasonably possible for you to do so, Pre-Service Claims must be submitted within the applicable time frames stated in this Certificate or in any riders or endorsements that amend this Certificate. For example, as stated in Sections 2 and 3, you must request Precertification *before* you receive Out-of-Network Services and within 48 hours after an Emergency Inpatient admission.

III. Appeals

Please see Section 9 for complete information about the Appeal Procedure. The Appeal Procedure is part of Anthem' Claim Procedure. By accepting this Certificate, you agree that you will not take legal action about a Claim Denial until you have exhausted the internal Appeal Procedure as stated in Section 9.

IV. General Claim Processing Information:

In most instances, claims are processed as follows:

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

BlueCard Program. The BlueCard Program is designed to make sure that you can take advantage of your membership anywhere in the United States. Your Anthem identification card (the “BlueCard”) is recognized by BlueCard Providers throughout the nation. Your BlueCard helps to keep your costs down when you need health care outside of New Hampshire, because you have no Post-Service Claim forms to file and BlueCard Providers accept their Local Plan’s maximum allowable benefit as payment in full. You do not pay amounts that exceed the maximum allowable benefit for Covered Services. When your care is furnished by a BlueCard Provider, the out-of-state Blue Cross and Blue Shield Plan determines the maximum allowable benefit based on either the provider’s charges for your Covered Services, or the Local Plan’s “ negotiated price,” whichever is lower.

Please note: often, the negotiated price consists of a simple discount. But sometimes it is an estimated final price based on expected settlements or other non-claims transactions with your BlueCard Provider (or with a specific group of BlueCard Providers). The negotiated price may also be a discount on billed charges, reflecting the Local Plan’s average expected savings. The estimated or average negotiated price may be adjusted in the future by the Local Plan to correct for overestimation or underestimation of past prices.

Should any state enact or reenact laws that mandate liability calculation other than as stated above, Anthem would then calculate your liability for any covered health care services received in such states using the methods outlined by the state laws 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. Mail your completed claim form to Anthem, along with the original itemized bill.

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

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

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

Member Satisfaction Services and Appeal Procedure

Section 9

Please see Section 11 for definitions of specially capitalized words.

This Section explains how to contact Anthem or the Behavioral Health Network (BHN) when you have questions, suggestions, concerns or complaints.

I. Member Satisfaction Services

Anthem and BHN provide quality member satisfaction services through our Customer Service Centers. All Anthem and BHN 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 Anthem and BHN policies and procedures,
- provide information or plan materials that you want or need (such as health promotion brochures, copies of your Network Directory, or replacement of identification cards),
- make sure your suggestions are brought to the attention of the appropriate persons at Anthem or BHN, and

- provide assistance to you (or your authorized representative) when you want to file an internal appeal.

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

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 other similar concerns), we encourage you to discuss your concerns directly with the provider before you contact a Customer Service Representative.

Anthem or BHN will respond to most of your questions or requests at the time of your call or within a few days. Please see article II (below) for complete information about Internal Appeals Procedure. You may have the right to an independent External Review, as summarized in this section under article III.

Please contact **Anthem's Customer Service Center** about your membership, Benefits, Covered Services, or plan materials (or about a Network Provider).

Call Anthem at: **1-800-870-3057**

Or, you may write to:

Anthem
PO Box 660
North Haven, CT 06473-0660

Please contact **BHN** for authorization of mental health or substance abuse care, or if you have questions about your Mental health or substance abuse care (or about a BHN Network Provider).

Call BHN at: **1-800-228-5975**

Or, you may write to:

The Behavioral Health Network (BHN)
One Pillsbury St., Suite 300,
Concord, NH 03301-3570

You may contact the **New Hampshire Healthy Kids Corporation** (NHHKC) for assistance at any time.

Call NHHKC at: **1-877-464-2447**

Or, you may write to:

New Hampshire Healthy Kids Corporation
25 Hall Street, Suite 302
Concord, NH 03301-4944

You may contact the **State of New Hampshire Insurance Department** for assistance at any time during business hours.

Call the Insurance Department at **1-800-852-3416 or (603) 271-2261**

Or, you may write to:

Life, Accident and Health Consumer Affairs Coordinator
State of New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

II. Internal Appeal Procedure

You have the right to receive Benefits for Covered Services, as described in this Certificate.

Please note that oral statements by agents or representatives of Anthem or BHN do not change the Benefits described in this Certificate. This article explains your *Internal Appeal Procedure*. Internal appeals are conducted and overseen by Anthem and BHN. No fees for submitting an appeal will be assessed against you or your authorized representative.

You may appeal any Post-Service or Pre-Service Claim Denial or other decision that Anthem or BHN makes about your coverage, your Benefits, or our failure to provide coverage or Benefits.

Please note: In addition to the *internal* appeal procedure described below, you may have the right to an *External Review* of an **Adverse Determination**. External Reviews are arranged through and overseen by the New Hampshire Insurance Department. For complete information about rights and restrictions, please see article III (below) and the *Managed Care Consumer Guide to External Appeal* (enclosed with this Certificate).

By accepting this Certificate, you agree that you will take no court action related to your coverage or care, before completing the steps described below. Your obligations are fulfilled when:

- first and second level internal appeals are completed as stated in this article, or
- you seek External Review of an Adverse Determination *before* completing the internal appeal procedure, in accordance with the terms of article III (below).

Who may submit an internal appeal?

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

- you submit a written statement in a form prescribed by Anthem, acknowledging the representation. To find out about required authorization forms, please contact the Customer Service phone number shown in I, above.
- 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 or BHN.

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

We may ask you to sign an authorization so that we can obtain medical records to conduct our review.

A. To exercise your right to an internal appeal, please take the following steps:

- **First Level Internal Appeal.** You may call or write to initiate a first level internal appeal. Letters should be addressed to "**First Level Appeal**" at the Anthem or BHN address shown in I (above). Your appeal must be submitted within at least 180 days of our first notification about the issue that caused you to appeal.
- **Second Level Internal Appeal.** If you are not satisfied with the result of your first level internal appeal, you or your authorized representative may appeal further. Second level internal appeals should be addressed to:

Second Level Appeal Committee

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. Your appeal must be submitted within at least 180 days of our notice stating the results of your first level internal appeal. You do not have to re-send the information that you submitted for your first level internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

If you are not satisfied with the outcome of your appeal to the Second Level Internal Appeal, the following steps may be taken:

- **Assistance from New Hampshire Healthy Kids Corporation.** You may contact the New Hampshire Health Kids Corporation. A Healthy Kids staff will work with you to review the claim and help clarify any misunderstandings. Please call **1-877-464-2447 for assistance.**
- **Assistance from the Department of Health and Human Services.** You may contact the Office of the Ombudsman at the New Hampshire Department of Health and Human Services. Please call **1-800-852-3345 (extension 6941)** for assistance.
- You may be eligible for an independent External Review overseen by the New Hampshire Insurance Department *before* completing the internal appeals process. Please see article III (below) for more information.

B. Time Frames for Appeal Determinations. Anthem or BHN will complete first and second level appeals within the following time frames. Time frames begin when we receive your appeal at each level (whether or not all of the necessary information is contained in the filing) and end when we make a claim determination and notify you at each level.

- **Expedited Appeals.** Please see Section 11 for a definition of “Urgent Care Claim.” 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 or BHN will make a decision and notify you as expeditiously as your medical condition requires, but in no event more than 72 hours *at each appeal level*. If an initial notice of the determination is not in writing, we will provide written confirmation of our decision within two business days.

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

If the Internal Appeal Procedure results are adverse to you, you may be responsible for paying the cost of noncovered services, according to the terms and conditions of this Certificate. Expedited Appeals are not available for Post-Service Claims.

- **Nonexpedited Pre-Service Claim Appeals.** Anthem or BHN will make a decision and notify you within a reasonable time appropriate to your medical circumstances, but in no event more than 15 days *at each appeal level*, unless you or your authorized representative fail to provide us with the information we need to make a determination. In the case of such failure, Anthem or BHN will notify you as soon as possible after receipt of the your appeal.
- **Post-Service Claim Appeals.** Anthem or BHN will make a decision and notify you within a reasonable time appropriate to your medical circumstances, but in no event more than 30 days *at each appeal level*, unless you or your authorized representative fail to provide us with the information we need to make a determination. In the case of such failure, Anthem or BHN will notify you as soon as possible after receipt of the your appeal.

The total time required to make a determination will not exceed the above time frames unless:

- You and Anthem or BHN agree mutually to extend the time frames, or

- Anthem or BHN finds that we need more information in order to make a determination. In such cases, we will consider the filing to be incomplete and we will inform you of the specific information we need within the time frames stated above. The period of time between the date of our request for information and the date we receive the information is “carved out” of (does not count against) the above stated time frames for completion of the appeal process. In the event that you fail, within a 45-day period from the date of notification, to provide sufficient information, Anthem or BHN may deny your appeal on the basis of incompleteness. Your appeal may be reopened at your request upon receipt of the required information.

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

III. External Review

You may have the right to an independent *External Review* of an Adverse Determination. “Adverse Determination” means a decision by Anthem or BHN or by a designated clinical review entity of Anthem or BHN, 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 or BHN’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. Therefore, Benefits are denied, reduced or terminated by Anthem or BHN.

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

Please note that the Insurance Department offers oversight of *standard and expedited* External Reviews.

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

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

- the service under appeal is a Covered Service and is not subject to an exclusion or an annual or lifetime maximum, as stated in this Certificate. Or, the service would be covered if certain clinical conditions were met and the decision about coverage is therefore an Adverse Determination. (For example, we may determine that a service is experimental, investigational or cosmetic and you disagree that the service is experimental, investigational or cosmetic. Another example is: we may deny coverage for care outside the network because we find that appropriate care can be provided in the network and you disagree with the finding), and
- Your cost for the care is (or is anticipated to be) at least \$400 in a 12-month period, and
- Your review request is not for the purpose of pursuing a claim or allegation of health care provider malpractice, professional negligence or other professional fault, and
- You have completed the *Internal Appeals Procedures* stated in 2 (above) and the final decision is adverse, or
- the time frames stated for completion of first or second level Internal Appeals Procedure are not met, or
- You and Anthem or BHN agree to submit the appeal for External Review *before* the Internal Appeal Procedure is completed.

B. Notice. We will provide complete notice of your External Review rights whenever:

- a second level internal appeal procedure is completed and the final decision is an Adverse Determination, or
- the time frame for completion of an internal Adverse Determination appeal is not met (our notification will be issued on the day that the time frame expires), or
- we come to agreement with you to waive the internal appeal procedure in order to seek External Review.

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

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

You must submit your *Request for Independent External Appeal of a Health Care Decision* to the New Hampshire Insurance Department no later than 180 days after the date of our notice. Please contact the Insurance Department if you need assistance with the request forms. The telephone number and address are shown in I (above).

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

The External Review process may terminate only if you submit new information to the Department of Insurance within the required time frame, and:

- we review the new information, and
- we reverse our Adverse Determination as a result of our reconsideration.

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

An Independent Review Organization's External Review decision is binding on Anthem and BHN. It is also binding on you, except to the extent that you have other remedies available under federal or state 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 and BHN have the right to deny Benefits for care that is not a Covered Service or is not Medically Necessary as defined in this Certificate or is otherwise not covered under the terms of this Certificate.

General Provisions

Section 10

Please see Section 11 for definitions of specially capitalized words.

No Assignment. You cannot assign any Benefits or monies due under this Certificate to any other person or entity. Any assignment by you will be invalid and have no effect. Assignment means to transfer your right to the Benefits provided under this Certificate to another person or entity.

Your Responsibility to Notify Anthem About Changes. It is your responsibility to inform Anthem of changes in your name or address. It is also your responsibility to inform Anthem when you need to add a Member or when a Member is no longer eligible for coverage under your Certificate. These notices should be made in writing to Anthem at the following address.

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

Notice of Change. If Anthem changes any provisions of this Certificate, you will be given reasonable notice before the effective date of the changes. If you continue premium payments as required, you will be considered to have accepted the changes and they will become part of your Certificate 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.

- **Right to Change the Certificate.** No agent or representative of Anthem or BHN has the right to change or waive any of the provisions of this Certificate without the approval of an authorized representative of Anthem.
- **Waiver.** Neither the waiver of a breach of, or a default under, any of the provisions of this Certificate, or the failure, on one or more occasions, to enforce any of the provisions of this Certificate, or to exercise any right or privilege under this Certificate, by Anthem or BHN, will ever be interpreted as a waiver of any subsequent breach or default of a similar nature, or of any such provisions, rights or privileges under this Certificate.
- **Governing Law.** This Certificate, the rights and obligations of Anthem, BHN and Members under this Certificate, and any claims or disputes relating thereto, will be governed by and interpreted in accordance with the laws of New Hampshire. This Certificate is intended for sale in the State of New Hampshire, and is intended at all times to be consistent with New Hampshire law. If New Hampshire laws, regulations or rules require Anthem to provide

Benefits that are not expressly described in this Certificate, the Certificate will be automatically amended only to the extent required by the laws passed by the State of New Hampshire. Anthem may adjust premiums to reflect additional Benefit requirements that are mandated by the State of New Hampshire.

Anthem is Not Responsible for Acts of Providers. Neither Anthem nor BHN is liable for the acts or omissions by any individuals or institutions furnishing care or services to you.

Right to Develop Guidelines. Anthem and BHN reserve the right to develop or adopt standards which set forth in more detail the instances and procedures when payments of Benefits will be made under this Certificate. Examples of the use of the standards are to determine whether care was Medically Necessary, whether emergency care was Medically Necessary, or whether certain services are skilled care. These standards will be interpretive and illustrative only and will not be contrary to any term or provision of this Certificate. If you have a question about the standards which apply to a particular Benefit, you may contact Anthem or BHN for further information.

Who Receives Payment under this Certificate. Anthem reserves the right to pay either you, the hospital, or any other provider. You are responsible for paying the provider for your cost sharing amounts and for non-covered services. The payment of Benefits due you are not assignable in whole or in part to any provider.

Recovery of Overpayments. On occasion, a payment may be made to you or on your behalf, when you are not covered, for a service which is not covered, or which is more than is appropriate for that service. When incorrect payment or overpayment is made, Anthem will notify you of the problem and you must return to Anthem within 60 days the amount of the mistaken payment or overpayment or provide Anthem with written notice stating the reasons why you may be entitled to such payment.

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

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

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

In this Certificate, you find “cross-references.” These cross-references are for your convenience only. Cross-references are not intended to represent all of the terms, conditions and limitations set forth in this Certificate.

Effective Date for Benefits. The effective date of your coverage under this Certificate is determined by the New Hampshire Healthy Kids Corporation. Benefits are available according to the coverage in effect on the “date of service.”

- For inpatient hospital charges, the date of admission is the date of service.
- For professional services in a hospital (such as inpatient medical care or surgery), the date of service is the date you receive the care.

- For Maternity Services, the date of service is the date of delivery, provided that the Maternity Services were furnished by one provider.
- For outpatient services (such as emergency room visits, outpatient hospital care, office visits, physical therapy or outpatient surgery), the date of service is the date you receive the care.

Acknowledgment of Understanding. Member, on behalf of itself hereby expressly acknowledges its understanding that this policy represents a contract solely between NHHKC and Anthem. Anthem Association, an association of independent Blue Cross and Blue Shield Plans, (“the Association”) which permits Anthem to use the Blue cross and/or Blue Shield service marks in the State of New Hampshire. Anthem is not contracting as the agent of the Association. Member on behalf of itself further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than NHKC and/or Anthem, and that no person, entity, or organization other than NHHKC and/or Anthem shall be held accountable or liable to Member for any obligations to Member created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions to this policy.

Definitions

Section 11

Throughout this Certificate Anthem Blue Cross and Blue Shield referred to as “Anthem,” “we,” “us,” or “our.” The words “you,” “your” and “yours” refer to the Member to whom this Certificate is issued.

Unless otherwise explained in the Certificate, capitalized words or phrases have the meaning as set forth in this Section:

Adverse Determination means a decision by Anthem or by BHN (or by a designated clinical review entity of Anthem or BHN), 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 or BHN’s requirements for *medical necessity, appropriateness, health care setting, level of care or effectiveness*. Therefore, Benefits are denied, reduced or terminated by Anthem or BHN.

Benefits means reimbursement or payments for health care available to Members under the Healthy Kids Silver program.

BHN Network Provider means a hospital or other Eligible Mental Health or Substance Abuse Provider who has an agreement with the Behavioral Health Network (BHN) to make Covered Behavioral Health Care (Mental Health and Substance Abuse) Services available to Members.

Calendar Year means January 1 to December 31.

Certificate means the description of the health care plan under which you receive health care Benefits. The Certificate includes this document, your identification card, and any endorsements and/or riders that amend your Member Coverage Certificate.

Claim Denial means any of the following: Anthem’s or BHN’s denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a member’s eligibility for

coverage under this Certificate. Claim Denial also includes Anthem's or [BHN]'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 our utilization review procedures, as well as our failure to cover a service for which benefits are otherwise provided based on our determination that the service is experimental, investigational or not Medically Necessary or appropriate.

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

Copayment means a fixed dollar amount that you must pay each time you receive a particular Covered Service.

Covered Service means services for which Benefits are available under this Certificate.

Designated Provider means the following duly licensed providers: hospitals, physicians, physical therapists, speech pathologists, doctors of osteopathy, doctors of podiatry, and duly licensed practitioners such as: audiologists, nurses (including nurse advanced registered nurse practitioners, and nurse-anesthetists), optometrists, physician assistants, and Network Diabetic Counselors. There are certain practitioners (such as dentists, acupuncturists, electrologists, and doctors of naturopathic medicine) whose services we will not cover as a general rule; thus, these practitioners are not considered Designated Providers.

Emergency Care means the Covered Services you receive due to the sudden onset of a serious medical condition. Emergency Care can be furnished in a licensed hospital emergency room. When Medically Necessary, you may be admitted to a hospital as a bed patient for Emergency Care. A serious condition is one that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could be expected to result in any of the following:

- serious jeopardy to your health;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part.

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.

Maximum Allowable Benefit (MAB) means the dollar amount available for a specific Covered Service. Anthem determines the MAB for approved Covered Services that you receive in New Hampshire. Anthem also determines the MAB for approved Covered Services that

you receive from a Non-Participating Provider outside New Hampshire. If you receive approved Covered Services from a Participating Provider outside of New Hampshire, the local Blue Cross and Blue Shield Plan determines the MAB. Network Providers and out-of-state Participating Providers accept the MAB as payment in full.

Medical Director means a physician licensed under RSA 329 and employed by Anthem who is responsible for Anthem's utilization review techniques and methods and their administration and implementation.

Medically Necessary means a service which:

- Provides for the diagnosis, prevention, or treatment of a covered medical condition;
- Is appropriate for the diagnosis, prevention, or treatment of a covered medical condition;
- Is within standards of good and generally accepted medical practice, as reflected by scientific and peer medical literature, and recognized within the organized medical community in the State of New Hampshire;
- Is not primarily for the convenience of the Member, his or her family, his or her physician, or another provider;
- Is care or treatment which could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered; and
- Is the most appropriate level of service or supply which can be provided safely and effectively.

Member means the child covered under this Certificate.

Network Diabetes Education Provider means a diabetes educator who has a written agreement with Anthem to provide diabetes education services to Members, as approved by Anthem.

Network Physician, Specialist, Hospital or Provider means any physician, specialist, health care professional, health care practitioner, hospital or other health care facility that has a written agreement with Anthem to provide Covered Services to Members.

Network Primary Care Physician (PCP) means a Network Physician who has a written agreement with Anthem regarding, among other things, willingness to provide Covered Services to Members as a Primary Care Physician and who is selected by a Member to be the Member's Primary Care Physician.

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

Non-Participating Provider means a Designated Provider that does not have a written payment agreement with any Blue Cross and Blue Shield Plan.

Out-of-Network Physician, Specialist, Hospital or Provider means any physician, specialist, health care professional, health care practitioner, pharmacy, hospital or other health care facility that does not have a written agreement with Anthem to provide Covered Services to Members.

Out-of-Network Services means Covered Services that you receive from an Out-of-Network Provider.

Participating Provider means a Designated Provider outside New Hampshire that is not a Network Provider, but that has a written payment agreement with the local Blue Cross and Blue Shield Plan.

PCP—Please see “Network Primary Care Physician (PCP)” in this Section.

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

Post-Service Claim means a claim for services that you have received and for which no Precertification review is required under the terms of this Certificate. Post-Service Claims do not include requests for reimbursement made by providers according to the terms of their agreements with Anthem, unless:

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

Precertification from Anthem is Anthem’s written confirmation that a service is Medically Necessary. Precertification from the Behavioral Health Network (BHN) is BHN’s written confirmation that Mental Health or Substance Abuse Services are Medically Necessary. Precertification is not a guarantee of Benefits. Benefits are subject to all of the terms and conditions of the Certificate that is in effect on the date that you receive Covered Services.

Pre-Service Claim means a claim that is covered in part or in whole only if you obtain Precertification from Anthem or BHN. For example, Section 1 describes Precertification requirements for Inpatient care and

for certain outpatient procedures. Benefits may be reduced or denied if you do not obtain Precertification as required. Requests for Precertification pursuant to the terms of this Certificate are Pre-Service Claims. Pre-Service Claims do not include requests for reimbursement made by providers according to the terms of their agreements with Anthem, unless Benefits for the proposed services are reduced or denied at the end of the Precertification process. Claims that meet the definition of a Post-Service Claim are not Pre-Service Claims.

Referral means a specific written recommendation by a Member's PCP that the Member should receive evaluation or treatment from a specific Designated Provider. A PCP must notify Anthem of a “Referral.” A PCP’s recommendation is a Referral only to the extent of the specific services approved by the PCP on the written Referral form. A general statement by a PCP that a Member should seek a particular type of service or provider does not constitute a Referral under this Certificate.

Service Area means the State of New Hampshire.

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 a state authorized and licensed institution 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.

Urgent Care Claim means any claim for medical care or treatment with respect to which the application of time periods for making non-urgent 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 care or treatment that is the subject of the claim.



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