



Individual and Family Health Care Plans
for **New Hampshire**

Our plans fit your plans



Lumenos[®] HSA Plus



Our plans help fit the way you live

In a world that's constantly changing, one thing's for certain: it's important to have health care coverage you can depend on — coverage designed to help fit your budget, and your way of life.

Since 1942, Anthem Blue Cross and Blue Shield has provided health care coverage and security to our New Hampshire neighbors.

You're in charge of your health and budget, and our Individual health care plans help keep it that way. We still offer a wide range of coverage options as unique as you are. And if you have any questions, we're here to help.

Experience you can rely on

Anthem is committed to helping simplify your life and improving your health. That's why we offer:

- **One of the largest provider networks in New Hampshire.**

With over 4,500 PPO doctors and more than 25 hospitals* throughout the state, chances are your doctor is one of ours.

- **Coverage that travels with you.**

No matter where life takes you, your health coverage goes with you. And the Blue Cross and Blue Shield Association's BlueCard® program makes it easy to access providers throughout the country.

- **Choose your doctor and compare your health care costs at anthem.com.**

Once you're a member, all you have to do is register at anthem.com and start feeling better about your choices with features like:

- **Find a Doctor:** Use our online Provider Directory to find hospitals, pharmacies and other specialists in your area - and check whether they are cost-saving network providers — all at the click of a mouse.
- **Anthem Care Comparison:** Save time and money by comparing the quality and safety of providers as well as the cost of common procedures at health care facilities in your area.
- **Zagat Health Surveys:** See what other patients have said about the doctors and hospitals you're considering. Add your own doctor recommendation, too!

Register at anthem.com and have a wealth of health information right at your fingertips.

Why do you need health care coverage?

These days, an average stay in the hospital can cost more than \$20,000.** The financial risk you take without health coverage just isn't worth it. Not only does health care coverage help you stay healthy, it also gives you added security, because you know you have help to protect against the high cost of unexpected medical bills.

*BCBSA Provider Data Counts, 2012.

**Based on 2008 weighted national estimates from HCUP Nationwide Sample (NIS), Agency for Healthcare research and Quality (AHRQ), based on data collected by individual States and provided to AHRQ by the states. (Average stay of 3.8 days; average cost to uninsured of \$22,512.)

Some definitions so we're all on the same page

Network Discounts: With Anthem, you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 4,500 PPO doctors and more than 25 hospitals*, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.

Cost-Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the cost, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year for covered services before your health care plan starts paying. Amounts met toward the deductible do not carryover from year to year. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. Network and non-network deductibles are separate and do not accumulate toward each other.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

Out-Of-Pocket Maximum is the most that you would pay in a calendar year for deductible and coinsurance for in-network covered services. Once you reach this maximum, the plan pays at 100% for most network services for the rest of the calendar year. There is a separate out-of-pocket maximum for non-network services. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand-name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand-name equivalent and have the same clinical benefit.

Brand-Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Formulary is a list of prescription drugs our health care plans cover. They may include generic, preferred brand-name and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans.

Health Savings Account (HSA) is a special bank account that can be set up by a member enrolled in a qualified HSA-compatible high deductible health plan if they choose. Contributions to this account can be made with certain tax advantages and funds from the account can be used for qualified health care expenses. See the insert from our preferred banking partner for more details and consult your tax advisor.

*BCBSA Provider Data Counts, 2012.

Lumenos[®] HSA Plus

Is this the right plan for you?

The Lumenos HSA Plus health plan is designed to give you more control over your health care costs. It helps you focus on getting healthy and staying that way.

Lumenos HSA Plus Plan Highlights

This plan offers traditional health care benefits that can be paired with a Health Savings Account (HSA) for more flexibility and potential tax advantages. The simple plan design makes using them that much easier.

Features:

- Preventive Care benefits that help you focus on staying healthy.
- PPO health plan coverage with a large array of benefits after you meet your deductible.
- Coverage compatible with an HSA that is yours to fund and keep if you choose. Use the HSA for qualified medical expenses or as a savings vehicle. Contact your tax advisor for possible advantages.
- Special programs for Smoking Cessation and Weight Management.
- Online tools for a personalized Health Assessment, prescription drug cost comparison, and other tools to give you more control.

You should know:

- Maternity benefits are available at an additional cost.
- Your Lumenos HSA Plus plan has a policy-level deductible and out-of-pocket maximum. Once covered members meet these amounts, the plan pays 100% of covered expenses. It's that simple.
- While Lumenos HSA Plus is compatible with a Health Savings Account, your health care plan works with or without it. You may set up the HSA now, later, or not at all. It's your choice.
- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.
- Mental health and Substance abuse services and prescription drugs are not covered by this plan.

Prescription Drug Coverage

Lumenos HSA Plus not only puts you in charge of your health care dollars, it can help you use those dollars for generic and brand-name prescription drugs in the way that best suits you.

Once your deductible is met, there is a coinsurance, if applicable, for covered prescription drugs. But even while you are meeting your deductible, you benefit from lower negotiated rates on prescription drugs at network pharmacies nationwide. There's no need to have a different deductible for prescriptions; it all works as one.

You will receive the highest level of benefits by asking your physician to prescribe a generic drug whenever possible. If you choose to purchase a brand-name drug when a generic drug is available, you will be responsible for the difference in the cost between brand-name and generic, plus your coinsurance.

And since you decide how to spend it, your Health Savings Account dollars can be used to pay for eligible prescription drugs while you are meeting your deductible.

Note: Visit [anthem.com](https://www.anthem.com) for more information on eligible expenses.

How to Customize your Lumenos HSA Plus Plan

Choose your deductible: You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you. Remember, any covered member can contribute to some or all of the policy deductible and out-of-pocket maximum, whether the policy covers one member or a whole household.

Use your Health Savings Account the way you want: Your HSA, if you choose to open one, is funded by you. So, it is yours to use for qualified health care expenses covered by the plan, or those not covered at all, like contact lenses. Your HSA is also yours to keep if you ever leave the plan; you won't lose those dollars if they're not used. In fact, the carryover from year to year can help you save for future financial needs. See the enclosed insert from our preferred banking partner for more information.

Other Optional Coverage: You can add more protection for you and your family by purchasing optional maternity coverage. See your Benefit Guide in the back of this brochure for more details.

Benefits

Calendar Year Deductible

Individual Policy	NETWORK:
	NON-NETWORK:
Family Policy	NETWORK:
	NON-NETWORK:

Network Coinsurance Options

Calendar Year Out-of-Pocket Maximum

Individual Policy	NETWORK:
	NON-NETWORK:
Family Policy	NETWORK:
	NON-NETWORK:

How family deductibles and family out-of-pocket maximums work

Lifetime Maximum

Covered Services

Doctors' Office Visits

Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)

Inpatient Services (overnight hospital/facility stays)

Outpatient Services (without overnight hospital/facility stays)

Emergency Room Services

Preventive Care Services

Maternity

Optional Coverage (at additional cost)

Prescription Drug Coverage

Retail Drugs (and Mail Order Drugs when available)

Optional Drug Coverage (when available)

Other Covered Benefits include but are not limited to:

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Contract/Policy. In the event of a conflict between the Contract/Policy and this Benefit Guide, the terms of the Contract/Policy will prevail.

Lumenos® HSA Plus

Your Choices

	\$1,750	\$2,500	\$4,000	\$5,950
	\$1,750	\$2,500	\$4,000	\$5,950
	\$3,500	\$5,000	\$8,000	\$11,900
	\$3,500	\$5,000	\$8,000	\$11,900
	20%*	0%*	0%*	0%*

Add Your Chosen Deductible to the Amount Below

	\$2,500	\$0	\$0	\$0
	\$6,750	\$2,500	\$4,000	\$5,950
	\$5,000	\$0	\$0	\$0
	\$13,500	\$5,000	\$8,000	\$11,900

For family plans (with two or more members) one member or any combination of family members can meet or contribute toward the family deductible and family out-of-pocket maximum.

None

Your Share of Costs (after deductible, unless waived or not subject to deductible)

NETWORK: 20% or 0% Coinsurance¹
NON-NETWORK: 40% or 30% Coinsurance¹

NETWORK: 20% or 0% Coinsurance¹
NON-NETWORK: 40% or 30% Coinsurance¹

NETWORK: 20% or 0% Coinsurance¹
NON-NETWORK: 40% or 30% Coinsurance¹

NETWORK: 20% or 0% Coinsurance¹
NON-NETWORK: 40% or 30% Coinsurance¹

NETWORK: 20% or 0% Coinsurance¹
NON-NETWORK: 20% or 0% Coinsurance¹

Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, and more.
NETWORK: 0% Coinsurance, not subject to deductible
NON-NETWORK: 40% or 30% Coinsurance¹

Not Covered (see Optional Coverage below)

Maternity

Lumenos HSA Plus

Generic drugs required if available. If a brand-name drug is purchased when generic was available, member pays the applicable copay/coinsurance plus the difference between the brand-name and generic.
Retail (90 day supply) or Mail Order (90 day supply):

NETWORK: 40% Coinsurance (with \$1750 deductible) or 0% Coinsurance (for all other deductible options)
NON-NETWORK: 40% Coinsurance (with \$1750 deductible) or 30% Coinsurance (for all other deductible options)

Not Available

Ambulance, Chiropractic Care, Durable Medical Equipment, Home Health and Hospice Care, Physical/Occupational Therapy, Speech Therapy, Urgent Care

*Your coinsurance will be higher with a non-network provider.

¹Coinurance is designated by the plan you choose.

Note: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Additional information

Because we're dedicated to making the application process simple, you can apply through the mail, online or over the phone.

Who can apply?

All individual plans are available to:

- New Hampshire residents.
- Applicants under age 18 are eligible to apply, but a parent or guardian must sign the application.
- Married couples and domestic partners that meet eligibility requirements may apply.
- Families with dependent children under age 26 are eligible.

Those applying must submit:

- An Enrollment Application
- Health Statement
- Your first month's premium

These health plans are medically underwritten. This means your premium and acceptance is based on a review of your medical history. The Subscriber Contract/Policy will be mailed to you once you are a member.

Sign up for our easy, no hassle payment option.

No matter which plan option you choose, we'll make it easy for you to make your monthly premium payments.

Through our Electronic Fund Transfer (EFT) program, we automatically withdraw funds from your bank account each month for the required premium amount. No check writing. No postage costs. No coverage lapse because you forgot to mail the payment. See ... we said we make it easy.

Sound good? Then complete the billing section of the Enrollment Application. If applying online, sign up for EFT while completing the online application.

**If you have questions
or want more details about
your options, call your
Anthem Sales Representative
or Broker today!**

Get a free look with a money-back guarantee!

After you enroll in a plan offered by Anthem, you will receive a Contract/Policy that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 10 days to examine your plan's features. During that time, if you are not fully satisfied, you may cancel your policy and your premiums will be refunded, less any claims that were already paid.



Individual health coverage. Your plans. Your choices.

Make sure you have all the facts.

To view a Summary of Benefits and Coverage please visit www.healthcare.gov.

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plans described – including what's covered, and what isn't. This policy has exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, contact your insurance broker, Anthem, or visit us on the web. You may also see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this from your computer, it should be at the end of this document. If you don't have this document, be sure to contact your Anthem Sales Representative or Broker.

This brochure is intended as a brief summary of benefits and services; it is not your Contract/Policy. If there is any difference between this brochure and your Contract/Policy, the provisions of the Contract/Policy will prevail. Benefits and premiums are subject to change.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Ready to enroll?

Call your Anthem Sales Representative or Broker today!



Individual and Family Health Care Plans for **New Hampshire**

Stay focused on your fitness.



Let ACS|BNY Mellon handle the finances.

You're only one check mark away

Simply make the selection on your application form. We'll take care of setting up your account. We'll also take care of sending you a Welcome Kit to get you started. All you have to take care of is your health. Which is, after all, the most important thing.

Setting up a Health Savings Account

The Lumenos[®] HSA Plus plans are a nice way to save on premiums. But that's just the tip of the savings iceberg. To realize your plan's full financial power, think about opening a health savings account to go with your Lumenos plan. The portability and tax savings of an HSA account can add up fast.

We've joined with Affiliated Computer Services (ACS) and The Bank of New York Mellon (BNY Mellon) to combine their HSA accounts with our Lumenos HSA Plus plans. Setting up your account with BNY Mellon is easy. Plus, it comes with built-in advantages and conveniences:

- A single customer service contact for the health plan and your HSA.
- A single online health site to access your plan benefit information and account details.
- Several payment and deposit choices, including special checks and automatic fund transfers.
- Competitive interest rates and investment opportunities for the funds in your account.

Of course, if you'd rather use another financial institution for your account, that's fine too.

A closer look

HSA Welcome Kit

If you make the selection on your application form, your Health Savings Account will automatically be set up once you're approved for the Lumenos HSA Plus plan, and you'll soon get an HSA Welcome Kit. In it, you'll find all of the banking documents and instructions for using your account. A separate application for your account is only needed if you choose a financial institution other than BNY Mellon.

This is what the IRS requires if you want to open a Health Savings Account:

- You must be covered by an HSA-compatible high deductible health plan (such as the Lumenos HSA plan).
- You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.
- You can't be covered by any other medical plan that is not an HSA-compatible high deductible health plan.
- You can't be enrolled in Medicare.
- You can't be claimed as a dependent on someone else's tax return.
- If you're a veteran, you may not have received veteran's benefits within the last three months.
- You can't be active military.

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum \$1,000 HSA balance. Investment choices include a number of mutual families. Once you're ready to invest, just call the ACS | BNY Mellon HSA Solution Contact Center at **866-686-4798** Monday through Friday from 8 a.m. to 8 p.m. (Eastern time) for a prospectus with more details.

Debit cards, checkbooks and online banking

Use your MasterCard® debit card, your HSA checkbook, or our new online banking option (provided by BNY Mellon) to pay your health care provider or pharmacy directly for eligible medical expenses, or to get cash from your account.

Deposits to your account

To contribute to your HSA, simply send a check and deposit slip to the address printed on your HSA checkbook. Or you can set up an electronic funds transfer between your bank and BNY Mellon for regular account contributions.

Account activity statements

Each month, you'll get a statement from BNY Mellon that shows all of your account activity. For an additional fee of \$0.75 per month, you can get a paper statement. Please go to anthem.com or call your dedicated Customer Service to learn how to elect this option. You'll also get IRS 1099 and IRS 5498 forms from BNY Mellon near tax time to help with tax preparation.

ACS | BNY Mellon HSA fee and rate schedule

A Deposit Agreement and a Disclosures and Fee Sheet will be in your HSA Welcome Kit. Please refer to those documents for the complete terms and conditions related to your account.

As good as these options may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Banking fees	
Monthly account fee	\$2.95
Debit card transactions	no charge
First two debit cards	no charge
Check writing	no charge
ATM transactions	\$1
Card replacement	\$5
Check reorder	\$10
Non-sufficient funds	\$25
Stop check service	\$25
Duplicate check	\$5
Periodic paper statement	\$0.75

ACS | BNY Mellon is an independent corporate entity that provides banking administration on behalf of Anthem Health Plans, Inc., d/b/a Anthem Blue Cross and Blue Shield. Anthem Blue Cross and Blue Shield is the trade name of: In Connecticut: Anthem Health Plans, Inc. In Maine: Anthem Health Plans of Maine, Inc. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association. Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

New Hampshire Coverage Details

Things you need to know before you buy...



Anthem Premier, Anthem SmartSense® and Lumenos® HSA Plus

Before choosing a health care plan, please review the following information, along with the other materials enclosed.

The plans outlined in this document are Major Medical Expense Coverage. Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the contract/policy.

Who can apply?

To be eligible for membership as a policyholder, the applicant must:

1. Be a resident of New Hampshire;
2. Agree to pay for the cost of premium that Anthem Blue Cross and Blue Shield (Anthem) requires; and
3. Satisfy the following requirements to guarantee renewability:
 - a) Eligibility criteria continues to be met;
 - b) There are no fraudulent or material misrepresentations on the application;
 - c) Membership has not been terminated by Anthem under the terms of this policy.

If an individual is under 26 years of age and is covered either by his or her biological parents or guardians as defined by the State of New Hampshire, he or she is eligible for coverage provided he or she meets eligibility criteria specified in the Eligibility policy stated above. Anthem requires the parent/guardian to sign the applications as the applicant for the insured. Applicants under age 18 are eligible to apply. Married couples and domestic partners that meet eligibility requirements may apply. Families with unmarried, dependent children up to age 26 are eligible as well. Those applying must complete a Health Statement. Acceptance into either plan is based on our review of your completed Application and Health Statement.

Pre-Existing Conditions

For members age 19 and older, there is an exclusion period for pre-existing conditions. A pre-existing condition means a condition, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received during the three months immediately preceding the effective date of coverage under your policy. Examples of care or treatment include, but are not limited to, health services such as: medication, office visits, tests, injections, therapies, hospitalization and use of medical equipment, supplies or devices.

No benefits are available for services that you receive in treatment of a pre-existing condition during the first nine months of coverage under your policy. The nine-month exclusion period begins on your effective date and ends nine months after your effective date. Services that you receive after the nine-month exclusion period ends will be covered, subject to all of the terms and conditions of your policy. Exception: If you were covered by a health plan before you enrolled in this plan, you may be entitled to receive proof of prior coverage from your prior plan. You should submit the proof to Anthem with your enrollment form or with a request for prior coverage credit. Anthem will credit any period of creditable coverage toward meeting the nine-month exclusion period described above. Coverage under most group health plans is creditable. Medicare, Medicaid and CHAMPUS are also examples of creditable coverage. Short-term, nonrenewable individual policies for medical, hospital or major medical coverage issued pursuant to RSA 415:5, III, or other law are also considered creditable coverage. Certain coverage is not creditable, as defined in NH RSA 420-G and other applicable laws. Examples of noncreditable coverages are: Medicare supplemental policies, separate policies covering only accident, disability, liability, auto liability or Workers' Compensation plans, nonmedical dental or vision benefits, long-term care policies or policies covering only specified diseases or illnesses. Please note that if you experienced a "break in coverage" equal to 63 or more consecutive days, the coverage you had before the break will not be credited. A "break in coverage" means a period of time when you were not covered under a public or private health insurance or health benefit plan (insured or self-insured) that is defined as "creditable coverage" under applicable laws, such as NH RSA 420-G.

Renewal/Termination of Coverage

Membership will not be terminated solely due to medical risk factors, such as health status or current or past medical conditions. We may not renew your coverage for the following reasons:

1. Nonpayment of required premiums
2. Any act or practice that constitutes fraud or intentional misrepresentation of material fact found on the application
3. If Anthem has notified the New Hampshire Insurance Department in accordance with all of the terms and conditions of NH RSA 420-G:6, VII, that it will cease to offer this coverage in New Hampshire's Individual market

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the precertification, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific time frames to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Precertification Review / Pre-Admission Review

Precertification review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that:

1) the procedure is medically necessary; and 2) the procedure meets your health care plan's specific guidelines prior to being performed.

Requests for precertification review may include, but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Precertification review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care, and assigns an expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians and member-assigned health care professionals (or member authorized representative), and takes place by telephone, electronically and/or on-site.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g., without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed health care professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

What Our Individual Health Plans Do Not Cover

The following limitations and exclusions will help you understand what your health care plan does not include. These are just some of the plans' limitations and exclusions. Please review your Subscriber Contract/Policy (including any riders, endorsements or amendments) for a complete description of coverage, limitations and exclusions. The Subscriber Contract/Policy will be mailed to you once you are a member. Anthem's internal appeal process is also described in the Subscriber Contract/Policy.

Exclusions

Benefits are not available for:

- Any services that is not medically necessary
 - Alternative Medicines or Complementary Medicine
 - Amounts That Exceed the Maximum Allowable Benefit
 - Artificial Insemination, assisted reproductive technologies and infertility drugs
 - Biofeedback Services
 - Care Furnished by a Family Member
 - Care Received When You Are Not Covered Under This Policy
 - Chelating Agents
 - Care or Complications Related To Non-covered Services
 - Chiropractic Services (Except as stated in Covered Services)
 - Claims submitted 12 or months after the date of service
 - Convenience Services
 - Cosmetic Services
 - Custodial or Convalescent Care
 - Dental Services
 - Disease or Injury Sustained as a Result of War or Participation in Riot or Civil Disobedience
 - Domiciliary Care
 - Educational, Instructional, Vocational Services and Developmental Disability Services
 - Experimental/Investigational Services
 - Food and Food Supplements (Except as required by applicable law)
 - Foot Care, Foot Orthotics and Corrective Shoes
 - Free Care
 - Government Programs
 - Health club memberships
 - Hospitalization and Other Services Related to Noncovered Care
 - Human organ transplants other than those listed in the Subscriber Contract as covered benefits
 - Mental Health and Substance Abuse services and prescription drugs
 - Medications related to travel
 - Missed Appointments
 - Maternity Services (Except as stated in Covered Services)
 - Nonmember Biological Parents
 - Nonprescription contraceptive medication and devices
 - Nutritional and/or dietary supplements (Except as required by applicable law)
 - Pre-existing Conditions Exclusion Period for Members age 19 and older
 - Premarital Laboratory Work
 - Preventive Care (Except as required by applicable law)
 - Private Duty Nurses
 - Processing Fees
 - Radial keratotomy or other surgery to correct vision
 - Rehabilitation Services (Except as stated in Covered Services)
 - Reversal of Voluntary Sterilization
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- Sclerotherapy for Varicose Veins and Treatment of Spider Veins (Except as stated in Covered Services)
- Services Not Specified as Covered
- Sex Change Treatment
- Smoking Cessation Drugs, Programs or Services
- Surrogate Parenting
- Transportation (Except as stated in Covered Services)
- Temporomandibular Joint Syndrome (TMJ)
- Vision Care
- Wigs (Except as required by law)
- Workers' Compensation
- Weight loss programs

Limitations

- Hearing Aid — 1 hearing aid per ear within a 60 month period
- Home Health Care/Respiratory Services — 100 visits per calendar year
- Chiropractic Therapy — 15 visits per calendar year
- Physical Therapy 20 visits per calendar year
- Occupational Therapy 20 visits per calendar year
- Speech Therapy 20 visits per calendar year
- Skilled Nursing Benefits 100 days per calendar year
- Rehabilitation Facility 100 days per calendar year
- Early Intervention Services — \$3,200 per member per calendar year and \$9,600 per Lifetime.
- Routine Pap Test — 1 per member per calendar year
- Routine PSA Test — 1 per member per calendar year
- Wigs — \$350 limit (as stated in contract)

In addition our Premier plan limits

- Routine vision exams — 1 per member per 12 months up to \$50

Your Rights and Responsibilities

We are committed to:

- Recognizing and respecting you as a member
- Encouraging your open discussions with your health care professionals and providers
- Providing information to help you become an informed health care consumer
- Providing access to health benefits and our network providers
- Sharing our expectations of you as a member

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Have privacy for your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.

- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.
- For assistance at any time, contact your local insurance department:
Phone: 800-852-3416
Write: Life, Accident and Health Consumer Affairs Coordinator
New Hampshire Insurance Department
21 Fruit Street, Suite 14
Concord, NH 03301

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits, or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers, in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

Access to the MIB

Information regarding your insurability will be treated as confidential. Anthem or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at **866-692-6901** (TTY: **886-346-3642**). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is

**50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734**

Information for consumers about MIB may be obtained on its website, at **www.mib.com**.

Anthem, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Notices of Privacy Practices

We've combined a couple of required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

State Notice of Privacy Practices

As mentioned in our HIPAA notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request.

HIPAA Notice of Privacy Practices

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or, to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law. If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is the genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How We Protect Information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who should not have access out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice.

A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Breast Reconstruction Surgery Benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy
- Surgery and reconstruction of the other breast to restore a symmetrical appearance
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema

All applicable benefit provisions will apply, including existing deductibles, copays and/or coinsurance.

The content of this document is not a legal policy or contract. It is intended as a quick reference to inform you about the health plans, programs and services available to individuals from Anthem in New Hampshire. Please refer to your contract/policy documents to determine your rights to benefits and coverage, as well as your obligations under the health plan you purchase.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Coverage Details, Enrollment Application and Health Statement. If you did not receive one or more of these materials, please contact your Anthem sales representative or Broker to request them.

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Lumenos HSA Plus Outline of Coverage

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Individual major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations that may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

Your Anthem Lumenos HSA Plus Subscriber Policy describes a partnership between you, your physician and Anthem. You are entitled to the Benefits described in the Policy. Certain rights and responsibilities are also described in the Policy.

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

Covered Services	Benefits *
Standard Deductible	<p><i>Please see page 1 of your Cost Sharing Schedule for your Copayment, Deductible and Coinsurance and Out-of-Network amounts.</i></p> <p>In-Network \$1,750 -\$5,950 per Member, per year* \$3,500 -\$11,900 per family, per year*</p> <p>Out of Network \$1,750 -\$5,950 per Member, per year * \$3,500 - \$11,900 per family, per year *</p>
Note: Separate In-Network and Out-of-Network deductibles. Family Deductible may be met by one or all family Members collectively.	
Standard Coinsurance	<p>In-Network 0-20%*</p> <p>Out-of-Network 30-40%*</p>

* Benefits are limited to the Maximum Allowed Amount (MAA). Under Out-of-Network Benefits, you may be responsible for paying the difference between the MAA and the provider's charge.

Daily Hospital Room and Board (semiprivate room rate) Miscellaneous hospital services	You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowed Amount after the Out-of Pocket Maximum has been met.
Emergency room charge	After you pay Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowed Amount after the Out-of Pocket Maximum has been met.
Surgical services	You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowed Amount after the Out-of Pocket Maximum has been met.
Anesthesia services	
In-hospital medical services	
Out-of-hospital care Office visits	After you pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowed Amount after the Out-of Pocket Maximum has been met.
Other Benefits durable medical equipment ambulance	You pay the Deductible and Coinsurance shown on your Cost Sharing Schedule. Covered Services will be paid at 100% of the Maximum Allowed Amount after the Out-of Pocket Maximum has been met.

Renewal. We may not renew your coverage for any of the following reasons:

- We do not receive your premium payment on time (due date plus the grace period). The “grace period” means a period of 31 days following the date which premium payment is due. Cancellation for nonpayment is considered cancellation by you, not Anthem, and is effective on the date the premium was due
- Anthem ceases to offer Lumenos HSA Plus coverage in New Hampshire’s individual market has provided 90 days notification to the New Hampshire Insurance Department and is otherwise in accordance with all of the terms and conditions of New Hampshire law regarding such action.

At the time of renewal, Anthem may modify Lumenos HSA Plus coverage, provided that the modification is applicable to all renewing Members.

Premiums. This is a medically underwritten benefit health plan. Your premium rate is based on Anthem’s review of your enrollment form, health statement and any other required information. Your initial premium is guaranteed for 12 months from your Effective Date, except that premium will automatically change when you add or remove a Member or when you change your coverage.

After your initial 12-month premium guarantee expires, your premium rate will automatically change when your age changes, you add or remove a Member or when you change your coverage. Your premium rate will also change if Anthem increases the rates for all Members who have coverage like yours. You will receive 60 days advance notice of premium rate changes not related to age, coverage change or membership changes. Anthem’s rating methods comply with all New Hampshire law.

Premium payments are due by the date stated on your invoice (usually the first of the month). There is a 31-day grace period.

Any significant misrepresentation or omission may cause Anthem to change your premium retroactive to the Effective Date of coverage. If the age of the Subscriber has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age

The following is a description of services that are not covered:

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

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

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

- A. Alternative Medicines or Complementary Medicine.** No Benefits are available for alternative or complementary medicine, even if the service is recommended by your physician and even if the services are beneficial to you. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven or established or medically documented or otherwise fails to meet Anthem’s definition of Medical Necessity as stated in Section 14 “Definitions”, as determined by Anthem’s Medical Director. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or

dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST) and iridology-study of the iris.

- B. Amounts That Exceed the Maximum Allowed Amount.** Benefits for Covered Services are limited to the Maximum Allowed Amount. As stated in this Policy and your riders and endorsements, you may be responsible for any amount that exceeds the Maximum Allowed Amount. See Section 14 "Definitions" for a definition of "Maximum Allowed Amount."
- C. Artificial Insemination.** In general terms, "artificial insemination" refers to insemination by any means other than natural sexual intercourse. No Benefits are available for artificial insemination, any assistive reproduction technology or any related service. Please see article I, F "Infertility Services" above in this Section for detailed information.
- D. Biofeedback Services.** Biofeedback services are not covered.
- E. 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.
- F. Care Furnished by a Family Member.** No Benefits are available for care furnished by an individual who normally resides in your household or is a member of your immediate family. Anthem defines your immediate family to include parents, siblings, spouses, children and grandparents.
- G. Care Received When You Are Not Covered Under This Policy.** No Benefits are available for any service that you receive before the Effective Date of this Policy.

If an Inpatient admission begins before the Effective Date of this Policy and you had no health coverage on the admission date, no portion of the admission (admission date to discharge date) is covered under this Policy.

If an Inpatient admission begins before the Effective Date of this Policy and this coverage replaces that of prior carrier, Benefits will be provided under this Policy for Inpatient days occurring *on or after the Effective Date of this Policy*, unless the terms of the prior carrier's policy provide coverage for the entire admission (admission date to discharge date). Please see Section 10.1.5 "Continuation of Coverage" in this Policy.

- H. 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.
- I. Care or Complications Related To Noncovered Services.** No Benefits are available for the cost of any noncovered services or for the cost of any care related to, resulting from, arising from or provided in connection with noncovered services or for complications arising from noncovered services. The limitations and exclusions found in this Section and in any other portion of this Policy apply, even if the service is furnished or ordered by your physician or other Designated Provider and/or the service meets Anthem's definition of Medical Necessity. Benefits for any complications resulting from noncovered or unauthorized services are excluded from coverage.
- J. Care Related to Noncovered Services.** No Benefits are available for hospital services or any other health care service related to, arising from, the result of, caused by or provided in connection with noncovered services or for complications arising from noncovered services. No Benefits are available for expenses incurred when you choose to remain in a hospital or another health care facility beyond the discharge time recommended by your physician, or by Anthem.
- K. Contraceptive Services.** No Benefits are available for nonprescription contraceptives or services related to nonprescription contraceptives. Examples of noncovered services are: contraceptive creams and foams, condoms, spermicidal jelly or contraceptive sponges.
- L. Convenience Services.** No Benefits are available for the cost of any service that is primarily for the convenience of a Member, a Member's family, or a Designated Provider. This exclusion applies even if the service is provided while you are ill or injured, under the care of a Designated Provider, and even if the

services are furnished, ordered or prescribed by a Designated Provider. Noncovered Convenience Services include, but are not limited to: telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while you are temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges

- M. Cosmetic Services.** No Benefits are available for Cosmetic Services. The cost of care related to, resulting from, arising from or medical conditions caused by or provided in connection with Cosmetic Services is not covered. No Benefits are available for care furnished for complications arising from Cosmetic Services. Cosmetic services are services primarily intended to change your appearance, to improve your appearance or are furnished for psychological reasons. For example, surgery or treatments to change the texture or appearance of your skin are not covered. No Benefits are available for surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except for the covered surgery described in Section 8, I "Limitations". No Benefits are available for any procedures, services, equipment or supplies provided in connection with cosmetic services.
- N. Custodial Care.** No Benefits are available for services, supplies or charges for Custodial Care. Custodial Care is not covered, even if the services are furnished or prescribed by a Designated Provider. Custodial Care is primarily for the purpose of assisting you in the activities of daily living and is not specific treatment for an illness or injury. It is care that has minimal therapeutic value and cannot in itself be expected to substantially improve a medical condition. Custodial Care is excluded, even if you receive the care during the course of an illness or injury while under the supervision of a Designated Provider, and even if the care is prescribed or furnished by a Designated Provider and is beneficial to you. Custodial Care is not covered, whether or not it is furnished in a facility (such as a Short-term General Hospital, Skilled Nursing Facility or Physical Rehabilitation Facility), at home or in another residential setting. Noncovered Custodial Care includes, but is not limited to:
- Assistance with walking, bathing, or dressing,
 - Oral hygiene, ordinary skin and nail care, maintaining personal hygiene or safety,
 - Transfer or positioning in bed,
 - Normally self-administered medicine,
 - Meal preparation,
 - Feeding by utensil, tube, or gastrostomy,
 - Routine maintenance of ostomies,
 - Catheter care,
 - Suctioning,
 - Using the toilet,
 - Enemas,
 - Preparation of special diets,
 - Supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel, and
 - Domiciliary Care. Domiciliary Care is care provided in a residential institution or setting, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included, and
 - Convalescent care. Convalescent care is Custodial Care that you receive during a period of recovery from an acute illness or injury.
- O. 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 due to a Member's participation or attempting to participate in a felony.
- P. Domiciliary Care.** Domiciliary care is care provided in a residential institution or setting, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included. Domiciliary care is Custodial Care and is not covered under any portion of this Policy.

Q. Educational, Instructional, Vocational Services and Developmental Disability Services. Except as stated in Section 7 “Covered Services”, article II “Outpatient Services”, no Benefits are available for educational or instruction programs or services. Noncovered services include, but are not limited to education evaluation, testing, classes, therapy, tutoring, counseling, programs, equipment or supplies. No Benefits are available for vocational/occupational evaluations, testing, classes, therapy, counseling, programs, equipment or supplies. Except as stated in Section 7 “Covered Services”, articles III “Outpatient Physical Rehabilitation Services” no benefits are available for services, counseling, therapy, supplies, equipment or programs for behavioral reasons or for Developmental Disabilities.

R. Experimental/Investigational Services. Anthem will not pay for Experimental/Investigational services. No Benefits are available for the cost of care related to, resulting from, arising from or provided in connection with Experimental/Investigational services. No Benefits are available for care furnished for complications arising from Experimental/Investigational services.

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

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

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

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

- The scientific evidence is not conclusory concerning the effect of the service on health outcomes;
- The evidence does not demonstrate that the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence does not demonstrate that the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence does not demonstrate that the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

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

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or

- Consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- The written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting providers and other experts in the field.

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

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

- S. Food and Food Supplements.** Except as required by applicable law, no Benefits are available for foods, food supplements or for vitamins. Please see Section 8 "Limitations and Exclusions", article I "Limitations", C for information about Benefits.
- T. 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.
- U. Free Care.** Benefits are not provided for any care if the care is furnished to you without charge or would normally be furnished to you without charge. This exclusion will also apply if the care would have been furnished to you without charge if you were not covered under this Policy or under any other health benefit plan or other insurance.
- V. Home Test Kits.** No Benefits are available for laboratory test kits for home use. These include, but are not limited to, home pregnancy tests and home HIV tests.
- W. Hospitalization and Other Services Related to Noncovered Care.** No Benefits are available for hospitalization or any other care related to noncovered services. No Benefits are available for services related to complications resulting from noncovered care, including care that is not ordered by a physician or care that is not Medically Necessary as determined by Anthem.
- X. 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.
- Y. Non-Hospital Institutions.** No Benefits are available for care or supplies in any facility that is not specifically stated as a covered facility in this Policy. 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.
- Z. Nonmember Biological Parents.** No Benefits are available for services received by the biological parent of an adopted child, unless the biological parent is a Member.
- AA. Preexisting Conditions Exclusion Period for Members age nineteen (19) and older.** A Preexisting Condition is any disease, ailment, or condition for which you received care or incurred medical expense at any time during the three month period immediately before the Effective Date of your Policy. "Care" or "medical expense" includes, but is not limited to health services such as: diagnosis, medication, office visits, tests, injections, therapies, hospitalization and use of medical equipment, supplies or devices. If you have a Preexisting Condition, no Benefits are available for services that you receive in treatment of

the condition for period of 9 consecutive months beginning on the Effective Date of this Policy.

Services that you receive after the Preexisting Condition Exclusion Period ends will be covered, subject to all of the terms and conditions of your Policy.

Please Note: For the purpose of identifying a Preexisting Condition, claims submitted with a total provider charge under \$1,000 (the Threshold), are generally not subject to review. For Members with Preexisting Condition Exclusions, any claim(s) submitted in excess of the Threshold may be reviewed to determine if the condition is preexisting. Once a Preexisting Condition has been established, all subsequent claims, regardless of provider charge amount, may be subject to review. As Anthem may apply a Threshold in its claims review, the payment of claims with a charge amount below the Threshold should not be relied upon as a representation that future claims related to the condition will be paid.

Crediting Prior Coverage Toward Meeting the Preexisting Condition Exclusion Period for Members age nineteen (19) and older. If you were covered by a health plan before you enrolled in this plan, you may be entitled to receive proof of prior coverage from the prior plan. You should submit the proof to Anthem with your enrollment form or with a request for prior coverage credit. Subject to all of the other terms and conditions of your Policy, *Anthem will credit periods of creditable coverage toward meeting the Preexisting Condition Exclusion Periods described above in this section.* Coverage under most group health plans is creditable. Further examples of creditable prior coverage are: Public Health Plans (including any plan established or maintained by our government, a state, or a foreign country or any political subdivision of our government, a state, or a foreign country that provides health coverage to individuals enrolled in the plan), Medicare, Medicaid and CHAMPUS/Tricare. Short-term, nonrenewable individual policies for medical, hospital or major medical coverage issued pursuant to law are also considered creditable coverage.

Certain coverage is not creditable, as defined in NH law and other applicable laws. Examples of noncreditable coverage are: Medicare supplemental policies, separate policies covering only accident, disability, liability, auto liability or workers' compensation plans, non-medical dental or vision benefits, long-term care policies or policies covering only specified diseases or illnesses.

Please note that if you experience a "break in coverage" equal to 63 or more consecutive days, the coverage you had before the break will not be credited. A "break in coverage" means a period of time when you are not covered under a public or private health insurance or health benefit plan (insured or self-insured) that is defined as "creditable coverage" under applicable laws, such as NH law and HIPAA. Any Waiting Period is disregarded and is counted toward *neither* a period of creditable coverage nor a break in coverage. Please see the definition of "Waiting Period" in Section 14 "Definitions" of this Policy.

When coverage under your Policy ends, a Certificate of Creditable Coverage will be issued to you. You should present the document to any succeeding carrier whose plan includes a preexisting condition exclusion period. Please call Customer Service if you have questions about Certificates of Creditable Coverage or to request a copy of your Certificate of Creditable Coverage. Anthem's toll-free Customer Service phone number is on page 2 of this Policy and on your identification card (1-888-224-4896).

- BB. Premarital Laboratory Work.** Premarital laboratory work required by any state or local law is not covered.
- CC. Private Duty Nurses.** Benefits are not provided for private duty nurses.
- DD. 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 Policy.
- EE. Rehabilitation Services.** No Benefits are available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No Benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning or for pulmonary rehabilitation programs. No Benefits are available for Inpatient or intensive outpatient treatment programs for substance abuse rehabilitation.
- FF. Reversal of Voluntary Sterilization.** We do not provide benefits for services to reverse voluntarily induced sterility.

GG. Sclerotherapy for Varicose Veins and Treatment of Spider Veins. Except when treatment is Medically Necessary as defined in Section 14 “Definitions” of this Policy. No Benefits are available for sclerotherapy for the treatment of varicose veins of the lower extremities including, but not limited to, ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by sclerotherapy or any other method is not covered under any portion of this Policy because such treatment is considered to be cosmetic and not Medically Necessary.

HH. Services Not Specified as Covered. No Benefits are available for services that are not specifically described as Covered Services in Sections 7 “Covered Services” and 8 “Limitations and Exclusions”, I of this Policy. This exclusion applies, even if your physician orders the service. Such noncovered services include, but are not limited to the following:

- services furnished by any individual or entity that is not a Designated Provider, except at the sole discretion of Anthem,
- services received by someone other than the patient, except as stated in I, H “Chelating Agents” (above) in this Section,
- 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
- fees, postage, taxes or other charges for the shipping or handling of covered equipment or services
prescription drugs purchased at a retail pharmacy, doctor’s office or through a mail service pharmacy for “take-home” use.
- nonlegend or over-the-counter drugs, medications, vitamins, minerals, supplements, supplies or devices, except as stated in Section 7 “Covered Services”. No Benefits are available under any portion of your Policy, 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 (see Section 8 “Limitations and Exclusions”, article I “Limitations”, C for coverage information). First aid supplies are not covered.

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

JJ. 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.

KK. Surrogate Parenting. Costs associated with surrogate parenting or gestational carriers are not covered. Services or supplies provided to a person not covered under the Policy in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple). Please see article I “Limitations”, F “Infertility Services” above in this Section for detailed information.

LL. Transportation. No Benefits are available for transportation costs, except as described in Section 7, II, E “Ambulance Services”.

MM. 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 and Anthem.

- NN. Wigs.** No Benefits are available for hair prostheses (wigs) except as required by law. Please see Section 8 "Limitations and Exclusions", article I "Limitations", C for Benefit information.
- OO. 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.
- PP. X-rays.** No Benefits are available for x-rays in connection with research or study. No Benefits are available for orthopantagrams (full dental x-rays or any x-rays to identify patterns of the dentition).
- QQ. Chiropractic Services.** No Benefits are available for services furnished or ordered by a chiropractor. No Benefits are available for services related to chiropractic care.
- RR. Weight loss programs.** Weight loss programs not approved by US, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Policy. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity.
- SS. Nutritional and/or dietary supplements,** except as provided in this Policy or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
- TT. Health club memberships,** exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
- UU. Vision Care** unless specifically show as covered in the Cost Sharing Schedule.
- VV. Treatment of Temporomandibular Joint Syndrome (TMJ)** or myofacial pain including removable appliances for TMJ repositioning and related surgery and diagnostic services. Benefits are not provided for fixed or removable appliances which involve movement or repositioning of the teeth (braces), or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures).
- WW. Mental Health and Substance Abuse** Benefits are not provided for Mental Health and Substance Abuse.
- XX. Medications** related to travel
- YY. Maternity Services.** No Benefits are available for services related to pregnancy unless you have purchased a Maternity Rider.

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