Benefit Booklet

(Referred to as “Booklet” in the following pages)

Anthem Blue Open Access POS HSA

E J Brooks Company

01-01-2026

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

Administered By

Anthem

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece en el reverso de su Tarjeta de Identificación.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Member Services at the number on the back of your Identification Card.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Act as well the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

- Without the need for Precertification;
- Whether the Provider is In-Network or Out-of-Network;

If the Emergency Services you receive are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. However, if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges, claims will be paid at the Out-of-Network benefit level. This means you will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This Notice and Consent process described below does not apply to Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility. Your Out-of-Pocket costs for claims for Covered Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

Out-of-Network Air Ambulance Services

When you receive Covered Services from an Out-of-Network Air Ambulance Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Air Ambulance Provider.

How Cost-Shares Are Calculated

Your cost shares for Surprise Billing Claims will be calculated based on the Recognized Amount. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility or for Covered Services provided by an Out-of-Network Air Ambulance Service Provider will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider, Covered Services from an Out-of-Network Provider at an In-Network Facility, or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprises Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Your Right to Appeal" section of this Benefit Book.

Provider Directories

Anthem is required to confirm the list of In-Network Providers in its Provider Directory every 30 days. If you can show that you received inaccurate information from Anthem that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost-shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

Anthem provides the following information on its website (i.e., www.anthem.com):

- Protections with respect to Surprise Billing Claims by Providers, including information on how to contact state and federal agencies if you believe a Provider has violated the No Surprises Act.

You may also obtain the following information on Anthem's website or by calling Member Services at the phone number on the back of your ID card:

- Cost sharing information for covered items, services, and drugs, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all In-Network Providers.

In addition, Anthem will provide access through its website to the following information:

- In-Network negotiated rates; and
- Historical Out-of-Network rates.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to the Claims Administrator's website, www.anthem.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

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

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

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

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

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits" for details.) If you would like more information on WHCRA benefits, call the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Employer to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on Mental Health and Substance Use Disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering Mental Health and Substance Use Disorder benefits cannot set day/visit limits on Mental Health or Substance Use Disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on Mental Health and Substance Use Disorder benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and Out-of-Pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than the predominant Deductibles, Copayment, Coinsurance and Out-of-Pocket expenses applicable to substantially all medical and surgical benefits in the same classification. Medical Necessity criteria are available upon request.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 60 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and Your Dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.
Eligible Subscribers and Dependents may also enroll under two additional circumstances:

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

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

To request special enrollment or obtain more information, call us at the Member Services telephone number on your Identification Card, or contact the Employer.

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Employer).

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

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

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

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

Introduction

This Booklet gives you a description of your benefits while you are enrolled under the health care plan (the "Plan") offered by your Employer. You should read this Booklet carefully to get to know the Plan's main provisions and keep it handy for reference. A thorough understanding of your coverage will allow you to use your benefits wisely. If you have any questions about the benefits shown in this Booklet, please call the Member Services number on the back of your Identification Card.

The Plan benefits described in this Benefit Booklet are for eligible Members only. The health care services are subject to the limitations and Exclusions, Copayments, Deductible, and Coinsurance rules given in this Benefit Booklet. Any group plan or Booklet which you received before will be replaced by this Booklet.

Your Employer has agreed to be subject to the terms and conditions of BCBS of GA Provider agreements which may include pre-service review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

Many words used in the Booklet have special meanings (e.g., Employer, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean the Claims Administrator or any of its subsidiaries, affiliates, subcontractors, or designees. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Member Services at the number on the back of your Identification Card. Also be sure to check the Claims Administrator's website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips.

Important: This is not an insured benefit Plan. The benefits described in this Booklet or any rider or amendments attached hereto are funded by the Employer who is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

High-Deductible Health Plan for Use with Health Savings Accounts

This Plan is meant to be federally tax qualified and used with a qualified health savings account. Approval by the Georgia Department of Insurance does not guarantee tax qualification and this Plan has not been submitted for approval by the IRS. Please seek the advice of a tax advisor.

How to Get Language Assistance

BCBS of GA is committed to communicating with our Members about their health Plan, no matter what their language is. BCBS of GA employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Table of Contents

Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "What's Covered" and Prescription Drugs section(s) for more details on the Plan's Covered Services. Read the "What's Not Covered" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Benefit Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Claims Administrator will allow for a Covered Service. Except as set forth in the Consolidated Appropriations Act of 2021 Notice, or as otherwise specified in this Booklet, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Benefit Period	Calendar Year
Dependent Age Limit	To the end of the month in which the child attains age 26. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Deductible	**In-Network**	**Out-of-Network**
Per Member	$3,500	$5,000
Per Family – All other Members combined	$7,000	$10,000

The In-Network and Out-of-Network Deductibles are separate and cannot be combined.

When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.

Copayments and Coinsurance are separate from and do not apply to the Deductible.

Coinsurance	**In-Network**	**Out-of-Network**
Plan Pays (unless otherwise noted)	90%	70%
Member Pays (unless otherwise noted)	10%	30%

Reminder: Except as set forth in the Consolidated Appropriations Act of 2021 Notice, or as otherwise specified in this Booklet, your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.

Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	$4,000	$10,000
Per Family – All other Members combined	$8,000	$20,000

The Out-of-Pocket Limit includes all Deductibles and Coinsurance you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.

The Out-of-Pocket Limit does not include amounts you pay for the following benefits:

- Out-of-Network Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy services.

No one person will pay more than their individual Out-of-Pocket Limit. Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles or Coinsurance for the rest of the Benefit Period, except for the services listed above.

The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.

Important Notice about Your Cost Shares

In certain cases, if a Provider is paid amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, such amounts may be collected directly from you. You agree that the Claims Administrator, on behalf of the Plan, has the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received". In these cases you should determine where you will receive the service (i.e., in a Doctor's office, at an outpatient Hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a Doctor's office, an outpatient Hospital facility, or during an Inpatient Hospital stay. For services in the office, look up "Office and Home Visits". For services in the outpatient department of a Hospital, look up "Outpatient Facility Services". For services during an Inpatient stay, look up "Inpatient Services".

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Ground, Air, and Water) Emergency Services	10% Coinsurance after Deductible	
For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment.		
Ambulance Services (Ground, Air, and Water) Non-Emergency Services	10% Coinsurance after Deductible	

Benefits	In-Network	Out-of-Network
For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment. **Important Note:** All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see "Getting Approval for Benefits" for details. Benefits for non-Emergency ground or water ambulance services will be limited to $50,000 per trip if an Out-of-Network Provider is used. This limit does not apply to air ambulance services.		
Autism Services		
• Applied Behavior Analysis	Benefits are based on the setting in which Covered Services are received.	
• All other Covered Services for autism	Benefits are based on the setting in which Covered Services are received.	
Cardiac Rehabilitation	See "Therapy Services".	
Cellular and Gene Therapy Services Precertification required	See the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" section later in this Schedule.	
Chemotherapy	See "Therapy Services".	
Chiropractic Services	See "Therapy Services".	
Clinical Trials / Cancer Clinical Trial Programs for Children	Benefits are based on the setting in which Covered Services are received.	
Dental Services (Limited to services for accidental injury, for certain Members requiring hospitalization or general anesthesia, or to prepare the mouth for certain medical treatments)	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care." Benefits for diabetic education are based on the setting in which Covered Services are received.	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Diagnostic Services		
• Reference Labs	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• All Other Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME), Medical Devices, and Supplies		
• Durable Medical Equipment	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Orthotics	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Prosthetics	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Prosthetic Limbs	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Medical and Surgical Supplies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Wigs	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period In- and Out-of-Network combined	
• Hearing Aids for Members through age18	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Hearing Aid benefit maximum for Members through age18	Limited to $3,000 per hearing aid per hearing impaired ear every 48 months In-and Out-of-Network combined	

Benefits	In-Network	Out-of-Network
Emergency Services		
Emergency Room		
• Emergency Room Facility Charge	10% Coinsurance after Deductible Coinsurance and Deductible waived if admitted	
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon)	10% Coinsurance after Deductible	
• Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	10% Coinsurance after Deductible	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	10% Coinsurance after Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	10% Coinsurance after Deductible	
As described in the "Consolidated Appropriations Act of 2021 Notice" for Emergency Services at the front of this Booklet, Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable. Please refer to the Notice at the beginning of this Booklet for more details.		
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Therapy Services" for details on Benefit Maximums.	
Home Health Care		
• Home Health Care Visits from a Home Health Care Agency (Including intermittent skilled nursing services)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Home Dialysis	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Home Infusion Therapy / Chemotherapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Specialty Prescription Drugs for Infusion / Injection – Other than Chemotherapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Home Health Care Services / Supplies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Private Duty Nursing (Including continuous complex skilled nursing services)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Home Health Care Benefit Maximum	Unlimited	
Home Infusion Therapy	See "Home Health Care."	

Benefits	In-Network	Out-of-Network
Hospice Care		
• Home Hospice Care	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Bereavement	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Inpatient Hospice	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Outpatient Hospice	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Respite Care	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Infertility Services	See “Maternity and Reproductive Health Services.”	
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Skilled Nursing Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Rehabilitation	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	60 days per Benefit Period In- and Out-of-Network combined	
• Mental Health / Substance Abuse Facility	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Residential Treatment Center	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Ancillary Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Surgery	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Maternity	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Mental Health / Substance Abuse Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Maternity and Reproductive Health Services		
• Maternity Visits (Global fee for the Ob-Gyn's prenatal, postnatal, and delivery services)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Inpatient Services (Delivery)	See "Inpatient Services".	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
• **Infertility Services** Limited to diagnostic services and treatment	Benefits are based on the setting in which Covered Services are received.	
Mental Health and Substance Use Disorder Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Occupational Therapy	See "Therapy Services".	
Office and Home* Visits		
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the "Outpatient Facility Services" section later in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
• Primary Care Physician / Provider (PCP)	In-Person Visits: 10% Coinsurance after Deductible Virtual Visits: 10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Additional Telehealth/Telemedicine Services from a Primary Care Provider (PCP) (as required by law)	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Mental Health and Substance Use Disorder Provider Including Psychotherapy and Habilitative / Rehabilitative Therapy Services	In-Person Visits: 10% Coinsurance after Deductible Virtual Visits: 10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Specialty Care Physician / Provider (SCP)	In-Person Visits: 10% Coinsurance after Deductible Virtual Visits: 10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Retail Health Clinic Visit	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Family Planning, Diabetes Education, and Nutritional Counseling (Medical)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Nutritional Counseling (Mental Health and Substance Use Disorder)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Nutritional Counseling for Obesity / Morbid Obesity Visit Maximum per Benefit Period	Limited to 4 visits per Benefit Period, In- and Out-of-Network combined	
The limits for nutritional counseling will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.		
• Allergy Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Diagnostic X-ray	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Office Surgery (including anesthesia)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Physical Therapy+	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
– Occupational Therapy+	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Speech Therapy+	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Pulmonary	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Cardiac Rehabilitation	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Dialysis / Hemodialysis	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Cognitive Rehabilitation Therapy+	10% Coinsurance after Deductible	30% Coinsurance after Deductible
See "Therapy Services" for details on Benefit Maximums.		
+If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.		
• Prescription Drugs Administered in the Office (other than allergy serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Orthotics	See "Durable Medical Equipment (DME), Medical Devices, and Supplies".	
Outpatient Facility Services		
• Facility Surgery Charge	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Facility Surgery Lab	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Facility Surgery X-ray	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Ancillary Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Doctor Surgery Charges	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant), Nutritional Counseling, and Diabetes Education	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Mental Health / Substance Use Disorder		

Benefits	In-Network	Out-of-Network
– Outpatient Facility Charges	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Professional Charges – Partial Hospitalization Program / Intensive Outpatient Program and Psychotherapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Professional Charges – Nutritional Counseling and Habilitative / Rehabilitative Therapies	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Diagnostic Lab	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Diagnostic X-ray	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Diagnostic Tests: EKG, EEG, etc.	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Physical Therapy+	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Speech Therapy+	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Occupational Therapy+	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Pulmonary Therapy	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Cardiac Rehabilitation	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Dialysis / Hemodialysis	10% Coinsurance after Deductible	30% Coinsurance after Deductible
– Cognitive Rehabilitation Therapy+	10% Coinsurance after Deductible	30% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		

Benefits	In-Network	Out-of-Network
[+]If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.		
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
Physical Therapy	See “Therapy Services”.	
Preventive Care	No Copayment, Deductible, or Coinsurance	30% Coinsurance no Deductible
No In-Network or Out-of-Network Deductible for preventive care services through age 5.		
Preventive Care for Chronic Conditions (per IRS guidelines)		
• Prescription Drugs	Please refer to the “Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits” section.	
• Medical items, equipment and screenings	No Copayment, Deductible, or Coinsurance	30% Coinsurance no Deductible
Please see the “What’s Covered” section for additional detail on IRS guidelines.		
Prosthetics	See “Durable Medical Equipment (DME), Medical Devices, and Supplies.”	
Pulmonary Therapy	See “Therapy Services”.	
Radiation Therapy	See “Therapy Services”.	
Rehabilitation Services	See “Inpatient Services” and “Therapy Services” for details on Benefit Maximums.	
Respiratory Therapy	See “Therapy Services”.	
Skilled Nursing Facility	See “Inpatient Services”.	
Speech Therapy	See “Therapy Services”.	
Surgery	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined. Benefit Maximum(s) for rehabilitative and habilitative visits are combined.	
• Physical, Occupational, Speech Therapy, Chiropractic Care / Manipulation Therapy and Pulmonary Rehabilitation (Habilitative)	60 visits per Benefit Period In- and Out-of-Network combined	
• Physical, Occupational, Speech Therapy, Chiropractic Care / Manipulation Therapy and Pulmonary Rehabilitation (Rehabilitative)	60 visits per Benefit Period In- and Out-of-Network combined	
• Cardiac Rehabilitation	36 visits per Benefit Period In- and Out-of-Network combined	
The limits for physical, occupational, speech, and cognitive rehabilitation therapy or nutritional counseling / nutritional therapy will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit (based on the primary diagnosis on the claim form). **Note:** The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice Care or the Inpatient Facility Services benefit. **Note:** When you get physical, occupational, speech therapy, cardiac rehabilitation or pulmonary rehabilitation in the home, the Home Care Visit limit will apply instead of the Therapy Services limits listed above. **Note:** If pulmonary rehabilitation is given as part of physical therapy, the Physical Therapy limit will apply instead of the Pulmonary Rehabilitation limit. **For Members receiving Applied Behavior Analysis (ABA) therapy and / or treatment of autism, visit limits do not apply.**		
Transplant Services	Please see “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services” summary later in this section.	
Urgent Care Services (Office & Home* Visits) *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
• Urgent Care Visit Charge	10% Coinsurance after Deductible	30% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Allergy Testing	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Diagnostic X-ray	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Office Surgery (including anesthesia)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (other than allergy serum)	10% Coinsurance after Deductible	30% Coinsurance after Deductible
If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Virtual Visits (from Virtual Care Only Providers)	Virtual Visits Conducted through our mobile app and website:	Other Virtual Visits:
• Virtual Visits including Primary Care from Virtual Care-Only Providers (Medical Services)	0% Coinsurance after Deductible	Please refer to the “Office and Home Visits” section.
• Virtual Visits from Virtual Care-Only Providers (Mental Health and Substance Use Disorder Services)	0% Coinsurance after Deductible	Please refer to the “Office and Home Visits” section.
• Virtual Visits from Virtual Care-Only Providers (Specialty Care Services)	10% Coinsurance after Deductible	Please refer to the “Office and Home Visits” section.
If Preventive Care is provided during a Virtual Visit, it will be covered under the “Preventive Care” benefit, as required by law. Please refer to that section for details.		
Vision Services (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received.	

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services

Please call our Transplant Department as soon as you think you may need a Covered Procedure to talk about your benefit options. To get the In-Network Level of benefits under your Plan, you must get certain Covered Procedures from an Approved In-Network Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an Approved In-Network Provider for certain Covered Procedures. Please see the "What's Covered" section for further details.

The requirements described below do not apply to the following:

- Cornea transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Procedure that you get before or after the Benefit Period.

Benefits for Covered Services that are not part of the Covered Procedure will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.

	Approved In-Network Provider	**All Other Providers**
Covered Procedure Benefit Period	The number of days or the applicable case rate / global time period will vary depending on the type of Covered Procedure and the Approved In-Network Provider agreement. Before and after the Covered Procedure Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending on where the service is performed.	Not applicable – There is no unique Benefit Period for services from All Other Providers
Inpatient Facility Services • **Precertification required**	10% Coinsurance after Deductible	30% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Inpatient Professional and Ancillary (non-Hospital) Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Outpatient Facility Services **Precertification required**	10% Coinsurance after Deductible	30% Coinsurance after Deductible

	Approved In-Network Provider	All Other Providers
		These charges will NOT apply to your Out-of-Pocket Limit.
Outpatient Facility Professional and Ancillary (non-Hospital) Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Travel Expenses		
• **Transportation and Lodging Limit** Deductible applies	Covered, as approved by us, up to $10,000 per Covered Procedure Benefit Period In- and Out-of-Network combined.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Human Organ or Tissue Transplant Procedure	10% Coinsurance after Deductible	30% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Donor Search Limit	Covered, as approved by us, up to $30,000 per transplant In- and Out-of-Network combined	
Live Donor Health Services **Inpatient Facility Services**	10% Coinsurance after Deductible	30% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Outpatient Facility Services	10% Coinsurance after Deductible	30% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Donor Health Service Limit	For Human Organ and Tissue Transplants, Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	**In-Network**	**Out-of-Network**
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered drug.		

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as Prior Authorization, quantity limits, and/or age limits and utilization guidelines. No day supply or quantity limits apply to prescriptions for inhalants to treat asthma.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days **Note:** A 90-day supply is available at Maintenance Pharmacies.	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy	30 days* *See additional information in the "Specialty Drug Copayments / Coinsurance" section below.	
PreventiveRx Note: No Copayment, Deductible, or Coinsurance applies to Prescription Drugs on the PreventiveRx Enhanced List when you use an In-Network Pharmacy. These Drugs are not covered if you get them from an Out-of-Network Pharmacy.		
Prescription Drug Coinsurance for PreventiveRx Prescription Drugs as listed on the PreventiveRx Enhanced List:	No Copayment / Deductible / Coinsurance up to the Plan's Maximum Allowable Amount.	
Level 1 Retail Pharmacy / Specialty Pharmacy:		
Tier 1 Prescription Drugs	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Tier 2 Prescription Drugs	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Tier 3 Prescription Drugs	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Tier 4 Prescription Drugs	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Level 2 Retail Pharmacy / Specialty Pharmacy:		
Tier 1 Prescription Drugs	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Tier 2 Prescription Drugs	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Tier 3 Prescription Drugs	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Tier 4 Prescription Drugs	10% Coinsurance after Deductible	10% Coinsurance after Deductible

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
*Certain contracted Retail Pharmacies can fill your Prescription at the same cost shares that apply to the Home Delivery Pharmacy level of benefits. Please ask your Pharmacy if they offer this special arrangement or call Pharmacy Member Services at the phone number on your ID Card for a list of Retail Pharmacies that offer the Home Delivery Pharmacy level of benefits.		
Home Delivery Pharmacy (Maintenance Drugs only) / Specialty Pharmacy:		
Tier 1 Prescription Drugs	10% Coinsurance after Deductible	Not covered
Tier 2 Prescription Drugs	10% Coinsurance after Deductible	Not covered
Tier 3 Prescription Drugs	10% Coinsurance after Deductible	Not covered
Tier 4 Prescription Drugs	10% Coinsurance after Deductible	Not covered
Specialty Drug (Includes Specialty Home Delivery):		
Please note that you may obtain certain Specialty Drugs from our Specialty Pharmacy or an In-Network Pharmacy that carries your Specialty Drugs. Please see “Specialty Pharmacy” in the section “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for further details. When you get Specialty Drugs from our Specialty Pharmacy, you will pay the same Copayments / Coinsurance you pay for a 30-day supply at an In-Network Pharmacy. **Note:** The Copayment and/or Coinsurance for oral chemotherapy Prescription Drugs for the treatment of cancer are covered as required by law. Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments / Coinsurance when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance. Note: If you are taking a Maintenance Medication, you may get the first 30 day supply and up to two additional 30 day prescription refills of the Maintenance Medication at your local Retail Pharmacy. After that, you will have to fill your prescription through the PBM’s Home Delivery Pharmacy to get the In-Network level of benefits. If you do not use the PBM’s Home Delivery Pharmacy, benefits will be covered at the Retail Pharmacy Out-Network level.		

How Your Plan Works

Introduction

Your Plan is a POS plan. The Plan has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more in out-of-pocket costs.

To find an In-Network Provider for this Plan, please see "How to Find a Provider in the Network," later in this section.

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level.

If you receive Covered Services from an Out-of-Network Provider after we failed to provide you with accurate information in our Provider Directory, or after we failed to respond to your telephone or web-based inquiry within the time required by federal law, your cost share for Covered Services will be based on the In-Network level.

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We, on behalf of the Employer, have final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with the Claims Administrator to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them you are an Anthem Member.
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

In-Network Provider Services

For services from In-Network Providers:

1. You will not be required to file any claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Booklet.

2. Precertification will be done by the In-Network Provider. (See the "Getting Approval for Benefits" section for further details.)

Please refer to the "Claims Payment" section for additional information on Authorized Services.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during a holiday and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room. If you are experiencing a mental health crisis, you may also call 988 for assistance.

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Booklet.

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments unless your claim involves a Surprise Billing Claim;

2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments) unless your claim involves a Surprise Billing Claim;

3. You will have to pay for services that are not Medically Necessary;

4. You will have to pay for non-Covered Services;

5. You may have to file claims; and

6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

Surprise Billing Claims

Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Booklet. Please refer to that section for further details.

Connect with Us Using Our Mobile App

As soon as you enroll in this Plan, you should download our mobile app. You can find details on how to do this on the Claims Administrator's website, www.anthem.com.

The goal is to make it easy for you to find answers to your questions. You can chat with live in the app, or contact the Claims Administrator via the website, www.anthem.com.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Search for a Provider in our mobile app.
- Contact Member Services to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area. Member Services can help you determine the Provider's name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.
- Check with your Doctor or Provider.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in the Reference Lab Network to get In-Network benefits. Please call Member Services before you get services for more information.

If you need details about a Provider's license or training, or help choosing a Doctor who is right for you, call the Member Services number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with the Claims Administrator to help with your needs.

Please note that Anthem has several networks, and that a Provider that is In-Network for one plan may not be In-Network for another. Be sure to check your Identification Card or call Member Services to find out which network this Plan uses.

Continuity of Care

If your In-Network Provider leaves our network for any reason other than termination for cause, retirement or death or if coverage under this Plan ends because your Employer's Contract ends, or because your Group changes plans**,** and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still get In-Network benefits. "Active treatment" includes:

1) An ongoing course of treatment for a life-threatening condition, including a chronic illness or condition. A chronic illness or condition is a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;
2) An ongoing course of treatment for a serious acute condition, (e.g., chemotherapy, radiation therapy and post-operative visits);
3) An ongoing course of treatment for pregnancy and through the postpartum period;
4) A scheduled non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such a surgery;
5) An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen your condition or interfere with anticipated outcomes, or
6) Continuing care benefits for Members undergoing a course of institutional or Inpatient care from the Provider or Facility and/or determined to be terminally ill and is receiving treatment for such illness from such Provider or Facility.

An "ongoing course of treatment" includes treatments for Mental Health and Substance Use Disorders.

In these cases, you may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If you wish to continue seeing the same Provider, you or your Doctor should contact Member Services for details. Any decision by us regarding a request for Continuity of Care is subject to the appeals process.

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Schedule of Benefits" for details on your cost-shares. Also read the "Definitions" section for a better understanding of each type of cost share.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard" which provides services to you when you are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the "Claims Payment" section.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only covered Members have the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Benefit Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting/place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem, on behalf of the Employer, may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the Utilization Review process, the medical policies, or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if it is decided your services are Medically Necessary. For benefits to be covered, on the date You get service:

1. You must be eligible for benefits;
2. Fees must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under Your Plan;
4. The service cannot be subject to an Exclusion under Your Plan; and
5. You must not have exceeded any applicable limits under Your Plan.

Types of Reviews

- **Pre-service Review –** A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.

- **Precertification –** A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Benefit Booklet.

  For admissions following Emergency Care, you, your authorized representative or Doctor must tell the Claims Administrator within 48 hours of the admission or as soon as possible. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

- **Continued Stay/Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

The Provider, facility or attending Physician should contact the Claims Administrator to request a Precertification or Predetermination review. The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is Responsible for Precertification?

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, facility or attending Doctor ("requesting Provider") will get in touch with the Claims Administrator to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	• The Provider must get Precertification when required
Out-of-Network/ Non-Participating	Member	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.
BlueCard Provider	Member (Except for Inpatient Admissions)	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • **BlueCard Providers must obtain Precertification for all Inpatient Admissions.**
NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.		

How Decisions are Made

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator, on behalf of the Employer, reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your Identification Card.

If you are not satisfied with the Plan's decision under this section of your benefits, please refer to the "Your Right To Appeal" section to see what rights may be available to you.

Decision and Notice Requirements

The Claims Administrator will review requests for benefits according to the timeframes listed below. Timeframes and requirements listed are based on Federal laws. You may call the telephone number on your Identification Card for additional information.

Request Category	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	7 calendar days from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	7 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the Claims Administrator will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed or if the information is not complete by the timeframe identified in the written notice, a decision will be made based upon the information received.

The Claims Administrator will give notice of its decision as required by Federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic**.**

Important Information

On behalf of the Employer, Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying Providers may be selected to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

Just because a process, Provider or Claim is exempted from the standards which otherwise would apply, it does not mean that this will occur in the future, or will do so in the future for any other Provider, claim or Member. The Plan may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by contacting the Member Services number on the back of your Identification Card.

The Claims Administrator also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and teamwork with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make any recommendation for alternate or extended benefits to the Plan on a case-by-case basis, if in our discretion the alternate or extended benefit is in the best interest of you and Anthem and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

What's Covered

This section describes the Covered Services available under your Plan. Your Covered Services are subject to all the terms and conditions listed in this Benefit Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" section for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read the "How Your Plan Works" section for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have inpatient surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Service". As a result, you should read all the sections that might apply to your claims.

You should also know that many of the Covered Services can be received in several settings, including a Doctor's office, or your home an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where and from whom you choose to get Covered Services, and this can result in a change in the amount you will need to pay. Please see the "Schedule of Benefits" for more details.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
  - From your home, the scene of accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - Between a Hospital and Skilled Nursing Facility or other approved Facility.

- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews. Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews. When using an air ambulance for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider selected, no benefits will be available. Please see the "Schedule of Benefits" for the maximum benefit.

You must be taken to the nearest Facility that can give care for your condition. In certain cases the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an ambulance service, even if you are not taken to a Facility.

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

a) A Doctor's office or clinic;
b) A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Autism Services

Your Plan includes coverage for the treatment of neurological deficit disorders, including autism.

Autism Spectrum Disorder (ASD)

Your plan covers certain treatments associated with autism spectrum disorder (ASD). Coverage for Autism Spectrum Disorder (ASD) includes but is not limited to the following:

- Habilitative or rehabilitative services;
- Diagnosis of autism spectrum disorder;
- Treatment of autism spectrum disorder;
- Pharmacy care;
- Psychiatric care;
- Psychological care; and
- Therapeutic care.

Please see the Schedule of Benefits for applicable benefit limitations for these treatments.

Behavioral Health Services

Please see "Mental Health and Substance Use Disorder Services" later in this section.

Biomarker Testing Services

Please see “Diagnostic Services” later in this section.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Cellular and Gene Therapy Services

Your Plan includes benefits for certain cellular and gene therapy services, when Anthem approves the benefits in advance through Precertification. See the section “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” for additional details.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic Services

Benefits are available for chiropractic treatments provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations, and treatment.

Benefits do not include the following:

1. Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
2. Nutritional or dietary supplements, including vitamins.
3. Cervical pillows.
4. Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

   i. The Department of Veterans Affairs.

   ii. The Department of Defense.

   iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services including services that are not part of approved clinical trials will be reviewed according to the Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services and reserves the right to exclude any of the following services:

i. The Investigational item, device, or service;
ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Cancer Clinical Trial Programs for Children

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

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Other Dental Services

The Plan will also cover Medically Necessary Hospital or Ambulatory Surgery Center charges and anesthesia for dental care if the Member:

1. Is under the age of 20;

2. Has a chronic disability due to mental and/or physical impairment that is likely to continue indefinitely; or

3. Has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes Equipment, Education, and Supplies

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a health care professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "health care professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this section. For information on Prescription Drug coverage, please refer to the "Prescription Drugs" section in this Benefit Booklet.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when allowed.

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QCT Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Biomarker Testing Services

This Plan provides coverage for Medically Necessary Biomarker Testing (which includes genetic testing) when ordered by a qualified health care provider operating within the Provider's scope of practice for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition when the test is sufficiently supported by medical and scientific evidence.

Biomarker Testing may require prior authorization depending on the type of test. Members may be financially responsible for charges/costs related to Biomarker Testing in whole or in part if the service and/or setting is not found to be Medically Necessary.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on State law.

Urgent Review	72 hours from the receipt of request
Non-urgent Review	**7** calendar days from the receipt of the request

Dialysis

Please see "Therapy Services" later in this section.

Durable Medical Equipment (DME), Medical Devices, and Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment

and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by the Claims Administrator. The Plan may limit the amount of coverage for ongoing rental of equipment. The Plan may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Hearing Aids

Benefits are provided for the following Medically Necessary hearing aids, this includes bone-anchored hearing aids, and related services for children 18 year of age and under:

- The initial hearing aid evaluation, fitting, dispensing and programming;
- Batteries and cords;
- Servicing, repairs, follow-up maintenance and adjustments;
- Ear molds and ear mold impressions;
- Auditory training; and
- Probe microphone measurements to ensure appropriate gain and output.

Coverage provides for the replacement of one hearing aid per hearing impaired ear every 48 months.

Benefits are limited. Please see the "Schedule of Benefits" to see any Deductible, Coinsurance, Copayment or other benefit limitations that may apply.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories;
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Cochlear implants.
- Wigs needed after cancer treatment. Please see the Schedule of Benefits for any limit that may apply.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment. If you are experiencing a mental health crisis, you may also call 988 for assistance.

Emergency Services

Benefits are available in a Hospital Emergency Room or freestanding Emergency Facility for services and supplies to treat the onset of symptoms for an Emergency, which is defined below. **Services provided for conditions that do not meet the definition of Emergency will not be covered.**

Emergency (Emergency Medical Condition)

"Emergency", or "Emergency Medical Condition" means a medical or Behavioral Health Condition, including a mental health condition or substance use disorder, of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's health or the health of another person in serious danger or, for a pregnant women, placing the women's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us.

Emergency Care

"Emergency Care" means a medical or behavioral health exam done in the Emergency Department of a Hospital or freestanding Emergency Facility, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient. Emergency Care may also include necessary services, including observation services, provided as part of the Emergency visit regardless of the department in which the services are provided.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. For Surprise Billing claims, the Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable and the Out-of-Network Provider has complied with the notice and consent process as described in the "Surprise Bill Legislation Notice" at the front of this Booklet. Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover them as an Authorized Service. Your cost shares will be based on the Recognized Amount, and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined using the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as you are stabilized. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details.

Treatment you get after your condition has stabilized is not Emergency Care. Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details on how this will impact your benefits.

Habilitative Services

Benefits also include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Please see "Therapy Services" later in this section for further details.

Home Health Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Home Health Care Provider in your home. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home health care Provider. Other organizations may give services only when approved by the Claims Administrator, and their duties must be assigned and supervised by a professional nurse on the staff of the home health care Provider or other Provider as approved.
- Therapy Services (except for Manipulation Therapy, which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Private duty nursing services

Benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Mental Health and Substance Abuse Services" section below.

Benefits may also be available for Inpatient Services in your home. These benefits are separate from the Home Health Care Services benefit, and are described in the "Inpatient Services" section below.

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

1. Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
2. Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
3. Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
4. Social services and counseling services from a licensed social worker.
5. Nutritional support, such as intravenous feeding and feeding tubes
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
7. Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
8. Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated caregiver and individuals with significant personal ties, for one year after the Member's death.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services, Cellular and Gene Therapy Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

Please call our Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this *before* you have an evaluation and/or work-up for a transplant. To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Covered Procedure

As decided by us, any Medically Necessary human solid organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Centers of Excellence (COE) Transplant Providers

- **Blue Distinction Center (BDC) Facility**: Blue Distinction facilities have met or exceeded national quality standards for transplant care delivery.

- **Centers of Medical Excellence (CME) Facility:** Centers of Medical Excellence facilities have met or exceeded quality standards for transplant care delivery.

In-Network Transplant Provider

A Provider that we have chosen and designated as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence for Transplant by us or has not been selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts the day of a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department as soon as you think you may need a Covered Procedure to talk about your benefit options. You must do this before you receive services. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network Transplant Provider rules, or Exclusions apply. Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Precertification is required before the Plan will cover benefits for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection and storage is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Transportation and Lodging

The Plan will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Procedure will be performed. Help with travel costs includes transportation to and from the Facility and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation

and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information or refer to IRS Publication 502.

For lodging and ground transportation benefits, the Plan will cover costs up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the city where the Covered Procedure is performed,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the Covered Procedure,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation,
- Meals.

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting *.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for a private room is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Claims Administrator. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother’s normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

1. Operating, childbirth, and treatment rooms and equipment.
2. Prescribed Drugs.
3. Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
4. Medical and surgical dressings and supplies, casts, and splints.
5. Diagnostic services.
6. Therapy services, including infusion therapy services.

Inpatient Professional Services

Covered Services include:

1. Medical care visits.
2. Intensive medical care when your condition requires it.
3. Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.
4. A personal bedside exam by a Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
5. Surgery and general anesthesia.
6. Newborn exam. A Doctor other than the one who delivered the child must do the exam.
7. Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

*When available in your area, certain Providers have programs available that may allow you to receive Inpatient Services in your home instead of staying in a Hospital. To be eligible, your condition and the Covered Services to be delivered must be appropriate for the home setting. Your home must also meet certain accessibility requirements. These programs are voluntary and are separate from the benefits under "Home Health Care Services." Your Provider will contact you if you are eligible, and provide you with details on how to enroll. If you choose to participate, the cost-shares listed in your Schedule of Benefits under "Inpatient Services" will apply.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services; and
- Medically Necessary fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to the Claims Administrator. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, the Plan may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, the Plan may not require a Provider to get authorization before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Abortion Services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother, or as a result of incest or rape. The Plan will also cover elective abortions.

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Prescription Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Mental Health and Substance Use Disorder Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

    - Observation and assessment by a physician weekly or more often,
    - Rehabilitation and therapy.

- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs and Intensive In-Home Behavioral Health Services.

- **Virtual Visits** as described under the "Virtual Visits (Telemedicine / Telehealth Visits)" section.

Examples of Providers from whom you can get Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed to give these services, when they must be covered by law.

Nutritional Counseling

Covered Services include nutritional counseling visits when referred by your Doctor as indicated in the Schedule of Benefits.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office and Home Visits

Covered Services include:

Office Visits for medical care (including second surgical opinion) to examine, diagnose, and treat an illness or injury.

Consultations between your Primary Care Physician and a Specialist, when approved by Anthem.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor and Primary Care Provider visits in the home are different than the “Home Health Care Services” benefit described earlier in this Benefit Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or nurse practitioners. Services are limited to routine care and the treatment of common illnesses for adults and children.

Walk-In Doctor’s Office for services limited to routine care and the treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor’s office.

Urgent Care as described in the “Urgent Care Services” later in this section.

Virtual Visits as described under the “Virtual Visits (Telemedicine / Telehealth Visits)” section.

Prescription Drugs Administered in the Office

Orthotics

Please see “Durable Medical Equipment (DME), Medical Devices, and Supplies”.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgery Center,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by the Claims Administrator.

Benefits include Facility and related (ancillary) charges, when proper, such as:

7. Surgical rooms and equipment,
8. Prescription Drugs including Specialty Drugs,
9. Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
10. Medical and surgical dressings and supplies, casts, and splints,
11. Diagnostic services,
12. Therapy services.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the "Diagnostic Services" benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:

    a. Breast cancer,
    b. Cervical cancer,
    c. Colorectal cancer. This includes the preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. It also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e., flexible sigmoidoscopy, CT colonography),
    d. High blood pressure,
    e. Type 2 Diabetes Mellitus,
    f. Cholesterol,
    g. Child and adult obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

    a. Women's contraceptives, sterilization treatments, and counseling. This includes Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives and patches and over-the-counter oral contraceptives (including emergency contraceptives) and male condoms. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. Some categories and classes of contraceptives do not have Generics available and, in each of these categories, at least one Brand Drug is available at $0 cost sharing when you receive it from an In-Network Provider. If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent is Medically Necessary because a Generic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Drug with $0 cost-sharing if your Provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. You or your Doctor can find the form online at https://file.anthem.com/Anthem_ABS_BrandContraceptiveCopayWaiverForm.pdf or by calling the number listed on the back of your ID Card. If Medical Necessity has been determined by your Provider, an exception will be granted and coverage of the Drug will be provided at $0 cost sharing. Otherwise, Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy".

    b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.

    c. Gestational diabetes screening.

5. Preventive care services for smoking cessation and tobacco cessation for members age 18 and older as recommended by the United States Preventive Services Task Force including:
    a) Counseling
    b) Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy

c) Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy, when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
   a) Aspirin
   b) Folic acid supplement
   c) Bowel preparations
   d) FDA-approved preexposure prophylaxis (PrEP), related services and monitoring including follow-up HIV testing and additional testing to monitor the effects of the PrEP medications.

Please note that certain age and gender and quantity limitations apply.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's websites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

Covered Services also include the following services required by state law:

- Lead poisoning screening for children.
- Routine mammograms.
- Appropriate and necessary childhood immunizations that meet the standards approved by the U.S. public health service for such biological products against at least all of the following:
  - Diphtheria,
  - Pertussis,
  - Tetanus,
  - Polio,
  - Measles,
  - Mumps,
  - Rubella,
  - Hemophilus influenza b (Hib),
  - Hepatitis B,
  - Varicella.

(Additional immunizations will be covered per federal law, as indicated earlier in this section.)

- Routine colorectal cancer examination and related laboratory tests.
- Chlamydia screening.
- Ovarian surveillance testing.
- Pap smear.
- Prostate screening.

Preventive Care for Chronic Conditions (per IRS guidelines)

Members with certain chronic health conditions may be able to receive preventive care for those conditions prior to meeting their Deductible, when services are provided by an In-Network Provider. These benefits are available if the care qualifies under guidelines provided by the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) (referred to as "the agencies").

This includes care for the following chronic conditions:

Preventive Care	For Members Diagnosed With
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia

Preventive Care	For Members Diagnosed With
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meters	Asthma
Glucometers	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

Please refer to the Schedule of Benefits for further details on how benefits will be paid.

Prosthetics

Please see “Durable Medical Equipment (DME), Medical Devices, and Supplies”.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

Smoking Cessation

Please see the “Preventive Care” section in this Benefit Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

1) Accepted operative and cutting procedures;
2) Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
3) Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
4) Treatment of fractures and dislocations;
5) Anesthesia and surgical support when Medically Necessary;
6) Medically Necessary pre-operative and post-operative care.

Oral Surgery

Important Note: Although this Plan provides coverage for certain oral surgeries, many types of oral surgery procedures are not covered by this medical Plan.

Benefits are also limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery performed to correct significant deformities caused by congenital or developmental abnormalities, illness, injury, or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy.

Note: This section does not apply to orthognathic surgery. See the “Oral Surgery” section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances which involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time. Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services –** Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Post-cochlear implant aural therapy –** Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.

- **Infusion Therapy**– Nursing, durable medical equipment and Prescription Drug services that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive rehabilitation therapy –** Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Prescription Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

Please see "Human Organ and Tissue Transplant" earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Virtual Visits (Telemedicine / Telehealth Visits)

Covered Services include virtual Telemedicine / Telehealth visits that are appropriately provided through the internet via video, chat or voice. This includes visits with Providers who also provide services in person, as well as virtual care-only Providers.

- "Telemedicine / Telehealth" means the delivery of health care or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing or secure instant messaging; interactive store and forward (asynchronous) technology. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited Audio-only Telemedicine services are eligible for mental and behavioral health services only according to state law.

Please Note: Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all Providers offer virtual visits.

Benefits do not include the use of facsimile, electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside the Claims Administrator's network, benefit Precertification, or Provider to Provider discussions except as approved under "Office and Home Visits."

If you have any questions about this coverage, please contact Member Services at the number on the back of your Identification Card.

Vision Services

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses and contact lenses except as listed in the "Prosthetics" benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs including Specialty Drugs that must be administered to you as part of a Doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any drug that must be administered by a Provider. This section applies when a Provider orders the drug and a medical provider administers it to you in a medical setting. Benefits for drugs that you inject or get through your Pharmacy benefits (i.e., self-administered drugs) are not covered under this section. Benefits for those drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before the Claims Administrator can decide if the drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one drug, drug regimen, or treatment be used prior to use of another drug or drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound ingredients within a compound drug are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. The Claims Administrator will give the results of its decision to both you and your Provider.

For a list of Prescription Drugs that need Precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section "Getting Approval for Benefits" for more details.

If Precertification is denied you have the right to file an appeal as outlined in the "Your Right to Appeal" section of this Booklet.

Designated Pharmacy Provider

Anthem, on behalf of the Employer, in its discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with Anthem. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider's office, you and your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider's office.

The Plan may also require you to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. The Claims Administrator reserves the right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. The Claims Administrator may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in the Claims Administrator's discretion, such change can help provide cost effective, value based and/or quality services.

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, you will not have coverage for that Prescription Drug.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of your Identification Card or check the website at www.anthem.com.

Therapeutic Equivalents

Therapeutic equivalents is a program that tells you and your Doctor about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic equivalent is right for you. For questions or issues about therapeutic Drug equivalents call Member Services at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy as outlined in the "Schedule of Benefits". The Claims Administrator uses a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Prescription Drugs are used properly. This includes checking that Prescription Drugs are based on recognized and appropriate doses and checking for drug interactions or pregnancy concerns.

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you by a medical Provider in a medical setting (e.g., doctor's office visit, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

Prescription Drug benefits may require prior authorization to determine if your Drugs should be covered. Your In-Network Pharmacist will be told if Prior Authorization is required and if any additional details are needed for the Claims Administrator to decide benefits.

Prior Authorization

Prescribing Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one drug, drug regimen, or treatment be used prior to use of another drug, drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of a Prescription Drug List (as described below).

You or your Provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of your Identification Card or check the website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in the Claims Administrators discretion, such change furthers the provision of cost effective, value based and/or quality services.

If prior authorization is denied you have the right to file an appeal as outlined in the "Your Right To Appeal" section of this Booklet.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy.
- Specialty Drugs.
- Self-administered drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Self-injectable insulin and supplies and equipment used to administration insulin.
- Continuous glucose monitoring systems.*
  ***Note:** Each component of the monitoring system will be subject to a separate Copayment / Coinsurance.
- Self-administered contraceptives, including oral contraceptive drugs, self-injectable contraceptive drugs, contraceptive rings, and contraceptive patches. Certain contraceptives are covered under the "Preventive Care" benefits. Please see that section for further details.
- Oral Chemotherapy
- Special food products or supplements when prescribed by a Doctor if the Claims Administrator agrees they are Medically Necessary.
- Flu Shots (including administration). These will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.
- Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, nonproprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Off-Label Drugs

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

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

An off-label drug is a drug prescribed for a use that is different from the use for which it was originally approved for marketing by the federal Food and Drug Administration.

Where You Can Get Prescription Drugs

Tiered Network

Your Plan has three levels of coverage. To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy. If you get Covered Services from any other In-Network Pharmacy, benefits will be covered at Level 2 and you may pay more in Deductible, Copayments, and Coinsurance.

Level 1 In-Network Pharmacies. When you go to Level 1 In-Network Pharmacies, (also referred to as Core Pharmacies), you pay a lower Copayment / Coinsurance on Covered Services than when you go to other In-Network Pharmacies.

Level 2 In-Network Pharmacies. When you go to Level 2 In-Network Pharmacies, (also referred to as Wrap Pharmacies), you pay a higher Copayment / Coinsurance on Covered Services than when you go to a Level 1 In-Network Pharmacy.

Level 3 Out-of-Network Pharmacies. When you go to Level 3 Out-of-Network Pharmacies, you will pay the highest Copayment/Coinsurance because these pharmacies are not in our network.

In-Network Pharmacy

You can visit one of the local Retail Pharmacies in the network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the drug. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription Drug and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to the Claims Administrator with a written request for payment.

Important Note: If it is determined that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, the Claims Administrator may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single In-Network Pharmacy. The Claims Administrator will contact you if it is determined that use of a single In-Network Pharmacy is needed and give you options as to which In-Network Pharmacy you may use. If you do not select one of the In-Network Pharmacies the Claims Administrator offers within 31 days, a single In-Network Pharmacy will be selected for you. If you disagree with the Claims Administrators decision, you may ask for it to be reconsidered as outlined in the "Your Right To Appeal" section of this Booklet.

If we determine that an In-Network Provider is demonstrating dispensing behavior that is potentially wasteful or an unsafe practice for you, we, on behalf of the Employer, may limit the medication(s) that the Provider can dispense. If so, you will be notified, and benefits will continue to be paid if you use another In-Network Pharmacy.

Specialty Pharmacy

The Claims Administrator keeps a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. The list of Specialty Drugs will change from time to time.

When you use the PBM's Specialty Pharmacy its patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Network Specialty Pharmacies and/or Specialty Drugs by calling Member Services at the phone number on the back of your Identification Card or check the Claims Administrator's website at www.anthem.com.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy that lets you get certain drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can have your Doctor send Prescriptions electronically, via fax or phone call, or you can submit written Prescriptions from your Doctor to the Home Delivery Pharmacy.

Home Delivery for Maintenance Medications – If you are taking a Maintenance Medication, you may get your Maintenance Medication at your local Retail Pharmacy or through Home Delivery Pharmacy. If you choose to get your Maintenance Medications from the Home Delivery Pharmacy, you can tell us your choice by phone at the number on the back of your ID Card or by visiting our website at www.anthem.com.

A Maintenance Medication is a drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a

Maintenance Medication, please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Please be aware that you can get Prescription Drugs from any local Pharmacy that agrees to accept the same payment terms as the PBM's Home Delivery Pharmacy.

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in the network. You will be charged the full retail price of the Prescription Drug and you will have to submit your claim for the Prescription Drug to the Claims Administrator. (Out-of-Network Pharmacies won't file the claim for you.) You can obtain a claims form from the Claims Administrator or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Prescription Drug;
- Cost of the Prescription Drug;
- Quantity (amount) of each covered Prescription Drug or refill dispensed.

You must pay the amount shown in the "Schedule of Benefits". This is based on the Maximum Allowed Amount as determined by the Claims Administrator's normal or average contracted rate with network pharmacies on or near the date of service.

What You Pay for Prescription Drugs

Tiers

Please note: To get the lowest out-of-pocket cost, you must get Covered Services from a Level 1 In-Network Pharmacy.

Your share of the cost for Prescription Drugs may vary based on the tier the drug is in as outlined in the "Schedule of Benefits".

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs, Biosimilars, Interchangeable Biologic Products.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred and non-preferred drugs that may be Generic, single-source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 4 Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.

Drugs are assigned to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We, on behalf of the Employer, decide coverage for doses and administration (i.e., oral, injection, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem Prescription Drug List, (a formulary), which is a list of Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain Drugs if they are not on the Prescription Drug List.

The Drug List is developed by us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over-the-counter medicines, Generic Drugs, the use of one Drug over another by our Members, and where proper, certain clinical economic reasons.

We, on behalf of the Employer, decide coverage based upon medication dosage, dosage forms, manufacturer, and administration methods (i.e., oral, injection, topical, or inhaled) and may cover one form instead of another as Medically Necessary.

You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Additional Information about the Prescription Drug Formulary

You may request a copy of the covered Prescription Drug list (Formulary) by calling the Member Services telephone number on the back of your Identification Card or by visiting our website at www.anthem.com. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

The Claims Administrator may only modify the Formulary for the following reasons:

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

PreventiveRx Benefits

Note: The PreventiveRx benefit covers Prescription Drugs in addition to those required by federal law under the "Preventive Care" benefit.

Your Plan includes the PreventiveRx benefit. This benefit waives Copayments, Coinsurance, and Deductibles on Prescription Drugs listed in the PreventiveRx Enhanced List. These drugs have been found useful in preventing disease or illness. You can get a copy of this list at www.anthem.com. This list will be reviewed and updated from time to time.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases you may be able to get an

early refill. For example, you may be able to refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call our PBM and ask for an override for one early refill. If you need more than one early refill, please call Member Services at the number on the back of your Identification Card.

Important Note: Prescriptions for inhalants prescribed to enable breathing in patients with asthma or other life-threatening bronchial ailments are not restricted by day supply limits and will be filled as ordered or prescribed by the treating Doctor.

Therapeutic Equivalents

Therapeutic equivalents is a program that tells you and your Doctor about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic equivalent is right for you. For questions or issues about therapeutic Drug equivalents call Member Services at the phone number on the back of your Identification Card.

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if your Prescription Drugs or dose changes between fills, by allowing only a portion of your prescription to be filled. This program also saves you Out-of-Pocket expenses. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these Prescription Drugs by calling the toll-free number on your member ID card or log on to the website at www.anthem.com.

Please note that Anthem may increase the cost share listed in the Schedule of Benefits in order to take full advantage of cost share assistance that is available from drug manufacturers. This will lower plan costs but will not increase your cost share obligation because if you take advantage of this assistance any additional cost share will be offset by the cost share assistance.

Rebate Impact on Prescriptions Drugs You get at Retail or Home Delivery Pharmacies

Anthem and/or its PBM may also, from time to time, enter into agreements that result in Anthem receiving rebates or other funds (“rebates”) directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by Anthem from rebates on Prescription Drugs purchased by you from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by you is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowed Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time you purchase the Prescription Drug, the amount of the rebate applied to your claim will be based on an estimate. Payment on your claim will not be adjusted if the later determined rebate value is higher or lower than our original estimate.

What's Not Covered

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

1. **Administrative Charges**
   a) Charges for the completion of claim forms,
   b) Charges to get medical records or reports,
   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
2. **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
3. **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   a) Acupuncture,
   b) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.
   c) Holistic medicine,
   d) Homeopathic medicine,
   e) Hypnosis,
   f) Aroma therapy,
   g) Massage and massage therapy except for massage therapy services that are part of a physical therapy treatment plan and covered under the "Therapy Services" section of this Booklet,
   h) Reiki therapy,
   i) Herbal, vitamin or dietary products or therapies,
   j) Naturopathy,
   k) Thermography,
   l) Orthomolecular therapy,
   m) Contact reflex analysis,
   n) Bioenergial synchronization technique (BEST),
   o) Iridology-study of the iris,
   p) Auditory integration therapy (AIT),
   q) Colonic irrigation,
   r) Magnetic innervation therapy,
   s) Electromagnetic therapy,
   t) Neurofeedback / Biofeedback.
4. **Adaptive Behavioral Treatment** (including, but not limited to Applied Behavior Analysis) for all indications except as described under Autism Services in the "What's Covered" section unless otherwise required by law.
5. **Autopsies** Autopsies and post-mortem testing.
6. **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
7. **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
8. **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

9. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet.
10. **Chats or Texts** Chats and texting are not a Covered Service unless appropriately provided via a secure and compliant application, according to applicable legal requirements.
11. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
12. **Clinically Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

    If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with the Claims Administrator. The Claims Administrator will cover the other Prescription Drug only if it agrees that it is Medically Necessary and appropriate over the clinically equivalent drug. The Claims Administrator will review benefits for the Prescription Drug from time to time to make sure the drug is still Medically Necessary.
13. **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to problems resulting from pregnancy.
14. **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
15. **Contraceptives** Non-prescription contraceptive devices unless required by law.
16. **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

    This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, or surgery to restore function of any body area that has been altered by illness or trauma.
17. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
18. **Crime** Treatment of injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
19. **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
20. **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
21. **Delivery Charges** Charges for delivery of Prescription Drugs.
22. **Dental Devices for Snoring** Oral appliances for snoring.
23. **Dental Treatment**

    Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as:

    - Removing, restoring, or replacing teeth;

- Medical care or surgery for dental problems (unless listed as a Covered Service in this Benefit Booklet);
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.

This exclusion does not apply to services that must be covered by law.

24. **Dental Services –** Dental services not described as Covered Services in this Benefit Booklet.
25. **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
26. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan. Quantity limits do not apply to prescriptions for inhalants to treat asthma. Quantity limits do not apply to prescriptions for inhalants to treat asthma.
27. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
28. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.
29. **Drugs Shared by Member Any** Drug prescribed to member that is subsequently shared with other individuals.
30. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.
31. **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
32. **Emergency Room Services for non-Emergency Care** Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes but is not limited to suture removal in an emergency room. For non-emergency care please use the closest In-network Urgent Care Center or your Primary Care Physician.
33. **Experimental or Investigational Services** Services or supplies that are found to be Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if the Claims Administrator deems it to be Experimental / Investigative.
34. **Eye Exercises** Orthoptics and vision therapy.
35. **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
36. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
37. **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
    a) Cleaning and soaking the feet.
    b) Applying skin creams to care for skin tone.
    c) Other services that are given when there is not an illness, injury or symptom involving the foot.
38. **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
39. **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

40. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

41. **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

    If your Group is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

42. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

43. **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

44. **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids including bone-anchored hearing aids, for Members over 18 years of age, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

45. **Home Health Care**

    a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a home health care Provider.

    b) Food, housing, homemaker services and home delivered meals.

46. **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

47. **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).

48. **Infertility Treatment** Testing or treatment related to infertility except for diagnostic services and procedures to correct an underlying medical condition. Infertility procedures not specified in this Benefit Booklet.

49. **Lost, Damaged, Destroyed or Stolen Drugs** Refills of lost, damaged, destroyed or stolen Drugs.

50. **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.

51. **Medical Equipment Devices and Supplies**

    a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

    b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

    c) Non-Medically Necessary enhancements to standard equipment and devices.

    d) Supplies, equipment and appliances, including hearing aids and wigs, that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense, including items you purchase with features that exceed what is Medically Necessary, will be limited to the Maximum Allowed Amount for the standard item, and the additional costs will be your responsibility.

    e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.

52. **Medicare** For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except, as required by federal law, as described in the section titled "Medicare"

in the “General Provisions” section. If you do not enroll in Medicare Parts A and/or B when you are eligible, and Medicare would be primary (e.g., for Members in retiree plans or COBRA Members entitled to Medicare we will calculate benefits as if you had enrolled. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

53. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
54. **New Prescription Drugs, Indications, and/or Dosage Forms** New Prescription Drugs, new indications and/or new dosage forms will not be covered until the date they are reviewed and determined to be eligible for coverage by our Pharmacy and Therapeutics (P&T) Process.
55. **Non-approved Drugs** Drugs not approved by the FDA.
56. **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
57. **Non-Medically Necessary Services** Services the Claims Administrator concludes are not Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
58. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that must be covered by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.
59. **Off label use** Off label use, unless we must cover it by law or if we approve it.
60. **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Benefit Booklet.
61. **Personal Care, Convenience and Mobile/Wearable Devices**
    a) Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs;
    b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads);
    c) Home workout or therapy equipment, including treadmills and home gyms;
    d) Pools, whirlpools, spas, or hydrotherapy equipment;
    e) Hypoallergenic pillows, mattresses, or waterbeds; or
    f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
    g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
62. **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the “Home Health Care Services” benefit.
63. **Prosthetics** Prosthetics for sports or cosmetic purposes.
64. **Residential Accommodations** Residential Accommodations to treat medical or Behavioral Health Conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, service, supplies or charges for the following:
    a) Domiciliary care provided in a residential institution, 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.
    b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
    c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even is psychotherapy is included.

d) Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or Mental Health or Substance Use Disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps

65. **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

66. **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely.

67. **Sanctioned or Excluded Providers** Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.

68. **Services Received Outside of the United States** Services rendered by Providers located outside of the United States, unless the services are for Emergency Care and Emergency Ambulance.

69. **Sexual Dysfunction** Services or supplies for male or female sexual problems (except male organic erectile dysfunction).

70. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

71. **Sterilization** Reversals of elective sterilizations are not covered. This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.

72. **Surrogate Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

73. **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

74. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

75. **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

76. **Vision Services** Vision services not described as Covered Services in this Benefit Booklet.

77. **Waived Cost-shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

78. **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Benefit Booklet.

    This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

79. **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any drug except for covered immunizations as approved.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
4. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Prescription Drug, unless required by law. "Clinically equivalent" means Prescription Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Prescription Drug is covered and which Prescription Drugs fall into this group, please call the number on the back of your Identification Card, or visit the Claims Administrator's website at www.anthem.com.

   If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with the Claims Administrator. The other Prescription Drug will be covered only if it is Medically Necessary and appropriate over the clinically equivalent Prescription Drug. Benefits for the Prescription Drug will be reviewed from time to time to make sure the Prescription Drug is still Medically Necessary.
5. **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
6. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
7. **Delivery Charges** Charges for delivery of Prescription Drugs.
8. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Prescription Drugs used with a diagnostic service, Prescription Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Prescription Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
9. **Drugs Not on the Prescription Drug List (a Formulary)** You can get a copy of the list by calling the Claims Administrator or visiting the website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.

   If you or your Doctor believes you need a certain Prescription Drug not on the list, please have your Doctor or pharmacist get in touch with us. The Plan will cover the other Prescription Drug only if we, on behalf of the Employer, agree that it is Medically Necessary and appropriate over the Drugs on the List. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
10. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Claims Administrator. Quantity limits do not apply to prescriptions for inhalants to treat asthma.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Prescription Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.

13. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.
14. **Family Members** Services prescribed, ordered, referred by or given by a member or your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
15. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
16. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" benefit. Please see that section for details.
17. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
18. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
19. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
20. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers and contraceptive devices. Items not covered under the "Prescription Drug Benefit at a Retail or home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment (DME), Devices, and Supplies" benefit. Please see that section for details.
21. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
22. **Lost, Damaged, Destroyed or Stolen Drugs** Refills of lost, damaged, destroyed or stolen Drugs.
23. **New Prescription Drugs, Indications, and/or Dosage Forms** New Prescription Drugs, new indications and/or new dosage forms will not be covered until the date they are reviewed and placed on a tier by our Pharmacy and Therapeutics (P&T) Process.
24. **Non-approved Drugs** Drugs not approved by the FDA.
25. **Non-Medically Necessary Services** Services the Claims Administrator concludes to be not Medically Necessary. This includes services that do not meet the Claims Administrator's medical policy, clinical coverage, or benefit policy guidelines.
26. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that must be covered by law. This Exclusion includes, but is not limited to nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
27. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
28. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when allowed to treat Members who are immunocompromised or diabetic.
29. **Over the Counter Items** Drugs, devices and products, or Prescription Drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device, or product may not be covered even written as a Prescription. This includes Prescription Drugs when any version or strength becomes available over the counter.

    This Exclusion does not apply to over-the-counter products the Plan must cover as a "Preventive Care" benefit under Federal law with a Prescription.

30. **Sanctioned or Excluded Providers** Any Drug, Drug regimen, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
31. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems. (except male organic erectile dysfunction).
32. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
33. **Weight Loss Drugs** Any drug mainly used for weight loss.

Claims Payment

This section describes how the Claims Administrator reimburses claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will still submit your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

Maximum Allowed Amount

General

This provision describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-network Providers is based on your Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Arrangements" later in this section for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement this Plan will allow for services and supplies:

- That meet the definition of Covered Services, to the extent such services and supplies are covered under your Plan and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance.

Generally, services received from an Out-of-Network Provider under this Plan Contract are not covered except for, under limited circumstances Emergency Care, certain services that are provided at an In-Network facility by an Out-of-Network Provider, or when approved in advance by Anthem as an Authorized Service when services have been previously authorized by Us. Except for Surprise Billing Claims*, as defined in this Contract, when you receive Covered Services from an Out-of-network Provider which have been previously authorized by us, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

**Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Please refer to that section for further details.*

When you receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowed Amount. The application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules reimbursement policies, and/or reimbursement requirements. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, the Maximum Allowed Amounts may be reduced for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network or an Out-of-network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for your Plan is the rate the Provider has agreed to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In-Network Provider or visit www.anthem.com.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on the Claims Administrator Out-of-network fee schedule/rate, which the Claims Administrator has established in its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Claims Administrator will update such information, which is adjusted or unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care; or

4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

5. An amount based on or derived from the total charges billed by the Out-of-Network Provider; or

6. Providers who are not contracted for this product, but are contracted for other products with Us are also considered Out-of-Network. For this Plan the Maximum Allowed Amount for services from these Providers will be one of the methods shown above unless the contract between Anthem and that Provider specifies a different amount or if your claim involves a Surprise Billing Claim.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount or if your claim involves a Surprise Billing Claim.

For Services rendered outside Anthem's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Claims Administrator would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount, this is called "balance billing". You are responsible for

paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network provider will likely result in lower Out-of-Pocket costs to you. Please call Member Services for help in finding an In-Network Provider or visit www.anthem.com.

Member Services is also available to assist you in determining your Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the treating Providers will render. You will also need to know the Provider's charges to calculate your Out-of-Pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by the Claims Administrator using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network or Non-Preferred Providers. Please see the "Schedule of Benefits" section in this Benefit Booklet for your cost share responsibilities and limitations, or call Member Services to learn how this Plan's benefits or cost share amounts may vary by the type of Provider you use.

The Plan will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your Provider for non-covered services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your Lifetime Maximum, benefit caps or day/visit limits.

If You receive Covered Services in an In-Network Provider facility from an Out-of-Network Provider who is employed by or contracted with the In-Network Hospital or facility, You will pay the In-Network Cost Share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges unless it's a Surprise Billing Claim. Note that We will not deny or restrict Covered Services provided by the In-Network Provider solely on the basis that You obtained services from an Out-of-Network Provider.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, the Plan may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact the Claims Administrator in advance of obtaining the Covered Service. If the Plan authorizes an In-Network cost share amount to apply to a Covered Service received from an, Out-of-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim involves a Surprise Billing Claim. Please contact Member Services for Authorized Services information or to request authorization.

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Claims Review

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balance billed

by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim in order for benefits to be paid.

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information needed to determine benefits. If the claim does not include enough information, the Claims Administrator will ask them for more details, and they will be required to supply those details within certain timeframes.

- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to the Claims Administrator, or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, you **c**an still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

    - Name of patient.
    - Patient's relationship with the Subscriber.
    - Identification number.
    - Date, type, and place of service.
    - Your signature and the Provider's signature.

    Out-of-Network claims must be submitted within 90 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 90-day period. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

    Please note that failure to submit the information we need by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Member's Cooperation

You will be expected to complete and submit to the Plan all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

Payment of Benefits

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to you as opposed to any Provider for Covered Services~~,~~ except for claims for Emergency Care or Surprise Billing Claims for air ambulance services or non-Emergency services performed by Out-of-Network Providers at certain In-Network Facilities, which will be paid directly to Providers and Facilities. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or You) will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to

receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Arrangements

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area the Claims Administrator serves (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. Explained below is how both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, the Claims Administrator will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Plan used for your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem Service Area by non-participating providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. **Exceptions**

In certain situations, the Plan may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment the Plan makes for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting Approval for Benefits" section in this Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Coreclaim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global CoreService Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Assignment

You authorize the Claims Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. The Claims Administrator also reserves the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an alternate recipient, or that person's custodial parent or designated representative. Any payments made by the Claims Administrator will discharge the Employer's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable Federal law.

Coordination of Benefits When Members Are Covered Under More Than One Plan

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

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

Please note that several terms specific to this section are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, your plan is referred to as "This Plan" and any other insurance plan as "Plan". In the rest of the Benefit Booklet, Plan has the meaning listed in the "Definitions" section.

Claim Determination Period means a Benefit Period Year. However, it does not include any part of a year during which you have no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

Plan means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured, that includes continuous twenty-four (24) hour coverage. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any Plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.
- "No-fault" and group or group-type "fault" automobile insurance policies or contracts.

Each contract or other arrangement for coverage under 1 or 2 above is a separate Plan. If an arrangement has two parts and these rules apply only to one of the two, each of the parts is a separate Plan.

Primary Plan/Secondary Plan means the "Order of Benefit Determination Rules" section states whether This Plan is a Primary Plan or Secondary Plan in relationship to another Plan covering you. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When there are more than two Plans covering you, This Plan may be a Primary Plan in relationship to one or more other Plans and may be a Secondary Plan in relationship to a different Plan or Plans.

This Plan means the part of this Plan that provides benefits for health care expenses.

Order of Benefit Determination Rules

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

- Automobile Insurance

  Medical benefits available through automobile insurance coverage will be determined before this Plan.

- Non-Dependent/Dependent

  The benefits of the program which covers the person as an Employee (other than as a Dependent) are determined before those of the program which covers the person as a Dependent.

- Dependent Child/Parents Not Separated or Divorced

  Except as stated below, when this program and another program cover the same child as a Dependent of different persons, called "parents":
  - The benefits of the program of the parent whose birthday falls earlier in a year are determined before those of the program of the parent whose birthday falls later in that year.
  - If both parents have the same birthday, the benefits of the program which covered the parent longer are determined before those of the program which covered the other parent for a shorter period of time.

  However, if the other program does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the programs do not agree on the order of benefits, the rule in the other program will determine the order of benefits.

- Dependent Child/Parents Separated or Divorced

  If two or more programs cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - first, the program of the parent with custody of the child;
  - then, the program of the spouse of the parent with custody of the child; and
  - finally, the program of the parent not having custody of the child.

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

- Joint Custody

  If the specific terms of a court decree state that the parents shall have joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the programs covering the child shall follow the order of benefit determination rules outlined above for "Dependent Child/Parents not Separated or Divorced."

- Active/Inactive Employee

  The benefits of a program that covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a program that covers that person as a laid-off or retired Employee (or as that Employee's Dependent). If the other program does not have this rule, and if, as a result, the programs do not agree on the order of benefits, this rule is ignored.

- Longer/Shorter Length of Coverage

  If none of the above rules determine the order of benefits, the benefits of the program which covered an Employee or Member longer are determined before those of the program that covered that person for the shorter time.

Effect on the Benefits of This Plan

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

Reduction in this program's benefits

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

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

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. The Claims Administrator has the right to decide which facts it needs. The Claims Administrator may get needed facts from or give them to any other organization or person as necessary to coordinate benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must provide any facts needed to pay the claim.

Facility of Payment

A payment made under another program may include an amount which should have been paid under This Plan. If it does, the Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this program. This Plan will not have to pay that amount again.

Right of Reimbursement

If the amount of the payment made by This Plan is more than it should have paid under this provision, the Claims Administrator may recover the excess from one or more of:

- the persons it has paid or for whom it has paid,
- insurance companies, or
- other organizations.

Subrogation and Reimbursement

These Subrogation and Reimbursement provisions apply when the Plan pays benefits as a result of injuries or illnesses You sustained, and You have a right to a Recovery or have received a Recovery from any source.

Definitions

As used in these Subrogation and Reimbursement provisions, “You” or “Your” includes anyone on whose behalf the Plan pays benefits. These Subrogation and Reimbursement provisions apply to all current or former plan participants and plan beneficiaries. The provisions also apply to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan’s rights under these provisions shall also apply to the personal representative or administrator of Your estate, Your heirs or beneficiaries, minors, and legally incompetent or disabled persons. If the covered person is a minor, any amount recovered by the minor, the minor’s trustee, guardian, parent, or other representative, shall be subject to these Subrogation and Reimbursement provisions. Likewise, if the covered person’s relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, or because of the death of the covered person, that Recovery shall be subject to this provision, regardless of how any Recovery is allocated or characterized.

As used in these Subrogation and Reimbursement provisions, “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, workers’ compensation insurance or fund, premises medical payments coverage, restitution, or “no-fault” or personal injury protection insurance and/or automobile medical payments coverage, or any other first or third party insurance coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements allocate or characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to, or stand in the place of, all of Your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan has the right to recover payments it makes on Your behalf from any party or insurer responsible for compensating You for Your illnesses or injuries. The Plan has the right to take whatever legal action it sees fit against any person, party, or entity to recover the benefits paid under the Plan. The Plan may assert a claim or file suit in Your name and take appropriate action to assert its subrogation claim, with or without Your consent. The Plan is not required to pay You part of any recovery it may obtain, even if it files suit in Your name.

Reimbursement

If You receive any payment as a result of an injury, illness or condition, You agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of Your recovery. If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf. You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

Secondary to Other Coverage

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by You to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary.

Assignment

In order to secure the Plan's rights under these Subrogation and Reimbursement Provisions, You agree to assign to the Plan any benefits or claims or rights of recovery You have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim You may have regardless of whether You choose to pursue the claim.

Applicability to All Settlements and Judgments

Notwithstanding any allocation or designation of Your Recovery made in any settlement agreement, judgment, verdict, release, or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery You make. Furthermore, the Plan's rights under these Subrogation and Reimbursement provisions will not be reduced due to Your own negligence. The terms of these Subrogation and Reimbursement provisions shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the terms of any settlement, judgment, or verdict pertaining to Your Recovery identify the medical benefits the Plan provided or purport to allocate any portion of such Recovery to payment of expenses other than medical expenses. The Plan is entitled to recover from any Recovery, even those designated as being for pain and suffering, non-economic damages, and/or general damages only.

Constructive Trust

By accepting benefits from the Plan, You agree that if You receive any payment as a result of an injury, illness or condition, You will serve as a constructive trustee over those funds. You and Your legal representative must hold in trust for the Plan the full amount of the Recovery to be paid to the Plan immediately upon receipt. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these Subrogation and Reimbursement provisions.

Lien Rights

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of Your illness, injury or condition upon any Recovery related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds from Your Recovery including, but not limited to, you, your representative or agent, and/or any other source possessing funds from Your Recovery. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset. The Plan shall be entitled to equitable relief, including without limitation restitution, the imposition of a constructive trust or an injunction, to the extent necessary to enforce the Plan's lien and/or to obtain (or preclude the transfer, dissipation or disbursement of) such portion of any Recovery in which the Plan may have a right or interest.

First-Priority Claim

By accepting benefits from the Plan, You acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before You receive any Recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Recovery, even if such payment to the Plan will result in a Recovery which is insufficient to make You whole or to compensate You in part or in whole for the losses, injuries, or illnesses You sustained. The "made-whole" rule does not apply. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs. The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. The duty to cooperate includes, but is not limited, to the following:

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its rights under these Subrogation and Reimbursement provisions, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:

1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
2. You fail to cooperate.

In the event You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.

You acknowledge the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 *et seq*, to share Your personal health information in exercising these Subrogation and Reimbursement provisions.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing its rights under these Subrogation and Reimbursement provisions.

Discretion

The Plan Administrator has sole discretion to interpret the terms of the Subrogation and Reimbursement provisions of this Plan in its entirety and reserves the right to make changes as it deems necessary.

Your Right To Appeal

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card.

For purposes of these Appeal provisions, "claim for benefits" means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the Plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure we will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, our notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the our determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA within one year of the appeal decision if you submit an appeal and the claim denial is upheld.
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on Medical Necessity or Experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- our notice will also include a description of the applicable urgent/concurrent review process; and
- we may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. Our review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

We shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time

frame allowed for us to complete our review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent between us and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact us at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- The date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral app*eals* is otherwise required by the nature of the *appeal* (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568; Atlanta, GA 30348-5568.

You must include Your Member Identification Number when submitting an appeal.

Upon request, we will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

We will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, we will provide you, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When we consider your appeal, we will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is Experimental, Investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, we will notify you of the outcome of the appeal as

soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, we will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, we will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from us will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

If we fail to resolve the appeal with the required time, you may pursue external review as described later in this section. This option is not available, however, if our failure to resolve the appeal is due to a de minimus violation that does not cause harm to you or is not likely to cause prejudice or harm to you, if the delay is for good cause or due to matters beyond our control, and is part of an ongoing, good faith exchange of information between you and us.

Voluntary Second Level Appeals

If you are dissatisfied with the mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to us within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless we determine that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent between us and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact us at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- The date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless we determine that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568; Atlanta, GA 30348-5568.

You must include Your Member Identification Number when submitting an appeal.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care Plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an Appeal before filing a Lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's decision on the claim or other request for benefits from which the appeal was taken shall be considered the Plan's final decision, and the one-year period in which a lawsuit or legal action must be brought shall run from the date of that final decision, not the date on which Anthem decided the appeal was untimely. You must exhaust the internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit Plan is sponsored by your Employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

Eligibility and Enrollment – Adding Members

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must be an Employee entitled to participate in the benefit Plan.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Plan, and be one of the following:

- The Subscriber's spouse. For information on spousal eligibility please contact your Employer. If spouses are not eligible under this Plan, any references to spouses in the “Eligibility and Enrollment – Adding Members” and “Termination and Continuation of Coverage” sections of this Booklet do not apply.

- The Subscriber’s or the Subscriber’s spouse’s children, including natural children, stepchildren, newborn and legally adopted children and children who the Plan has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.

- A child of a covered Dependent (i.e., a grandchild of the covered Subscriber or the Subscriber's covered spouse) as described below:

    - The mother or father of the child is a covered dependent under the age of 26 if the grandchild is enrolled from birth,
    - The subscriber is the legal guardian or court ordered custodian of the grandchild,
    - The subscriber has adopted the grandchild.

    Note: The request for enrollment must include a copy of the birth certificate. The request to enroll from birth must be received within 60 days of the birth. If not received in a timely manner the grandchild is not eligible.

- Children for whom the Subscriber or the Subscriber’s spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- Your Dependent children through the end of the month in which they attain age 26, legally adopted children from the date you assume legal responsibility, children for whom you assume legal guardianship and stepchildren. Also included are your children (or children of your spouse) for whom you have legal responsibility resulting from a valid court decree.

- Children who are mentally or physically impaired and totally dependent on you for support, regardless of age, with the exception of incapacitated children age 26 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Plan or prior creditable coverage prior to reaching age 26. Certification of the impairment is required within 31 days of attainment of age 26. A certification form is available from your Employer or from the Claims Administrator and may be required periodically but not more frequently than annually after the two year period following the child's attainment of the limiting age.

The Plan may require you to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

To obtain coverage for children, the Plan may require you to give the Claims Administrator a copy of any legal documents awarding guardianship of such child(ren) to you.

Types of Coverage

The types of coverage available to the Employee are indicated at the time of enrollment through the Employer.

When You Can Enroll

Initial Enrollment

Your Employer will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on any applicable waiting period, and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during an Open Enrollment period or during a Special Enrollment period, as described in this section.

Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. Your Employer will notify you when Open Enrollment is available.

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 60 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact;
- Exhausted COBRA benefits or Employer contributions toward coverage were terminated;
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 60 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and Children's Health Insurance Program Special Enrollment

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

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

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Employer's Prior Plan

Members who were previously enrolled under another plan offered by the Employer that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically for 31 days from the moment of birth. Following the birth a child, you should submit an application / change form to the Group within 60 days to add the newborn to your Plan.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send the Plan the completed application / change form within 31 days of the event. If, however, additional premium is required for the adopted Dependent, your Dependent's Effective Date will be the date of the adoption or placement for adoption, only if you notify the Plan of the adoption and pay any required additional premium within 31 days of the adoption.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, the Claims Administrator will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan in accordance to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the "Schedule of Benefits".

Updating Coverage and/or Removing Dependents

You are required to notify the Plan Administrator of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Plan Administrator and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;

- Dependent child reaching the Dependent Age Limit (see “Termination and Continuation of Coverage”);
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify the Plan Administrator of individuals no longer eligible for services will not obligate the Plan to cover such services, even if premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that the Plan may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage as provided in the “Termination and Continuation of Coverage” section. The Plan will not use a statement made by you to void your coverage after that coverage has been in effect for two years. This does not apply, however, to fraudulent misstatements.

Termination and Continuation of Coverage

Termination

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Administrative Services Agreement between the Employer and us terminates. If your coverage is through an association, your coverage will terminate when the Administrative Services Agreement between the association and us terminates, or when your Employer leaves the association. It will be the Employer's responsibility to notify you of the termination of coverage.

- If you choose to terminate your coverage.

- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, you must notify the Employer immediately. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

- If you elect coverage under another carrier's health benefit plan, which is offered by the Employer as an option instead of this Plan, subject to the consent of the Employer. The Employer agrees to immediately notify us that you have elected coverage elsewhere.

- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30-calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or Fees paid for such services.

- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Fees, the Employer may terminate your coverage and may also terminate the coverage of your Dependents.

- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Employer. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowed Amount for services received through such misuse.

You will be notified in writing of the date your coverage ends by either us or the Employer.

Removal of Members

Upon written request through the Employer, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by an Employer that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Employer's health Plan. It can also become available to other Members of your family, who are covered under

the Employer's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Employer.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

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

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

Qualifying Event	Length of Availability of Coverage
For Subscribers: Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
For Dependents: A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
For Dependent Children: Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case, a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Employer Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a

bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Employer will offer COBRA continuation coverage to qualified beneficiaries only after the Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

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

Disability extension of 18-month period of continuation coverage

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

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

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

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

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Employer's health Plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years and in certain instances more than five years, of military leave.

"Military service" means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Employer following completion of your military leave. Subscribers must return to work within:

a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.

b) 14 days after completing military service for leaves of 31 to 180 days,

c) 90 days after completing military service for leaves of more than 180 days; or

2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service for leaves of 31 to 180 days; or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any waiting / probationary periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the “What’s Not Covered” section.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Employer may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

General Provisions

Care Coordination

Anthem, as the Claims Administrator, pays In-Network Providers in various ways to provide Covered Services to you. For example, sometimes Anthem may pay In-Network Providers a separate amount for each Covered Service they provide. Anthem may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, Anthem may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, Anthem may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to Anthem under these programs.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, we will make a good-faith effort to ensure Covered Services are available to you. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster, epidemic, war, when health care services covered under this Plan are delayed or rendered impractical, or other events beyond our control. Under such circumstances, we will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Plan or the Claims Administrator.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing the Claims Administrator's policies and procedures regarding the protection, use and disclosure of your medical information is available on the Anthem website and can be furnished to you upon request by contacting the Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Medical Benefit Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a contract solely between the Employer and us, Blue Cross and Blue Shield Health Plan of Georgia (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Georgia. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee.

The Employer, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this contract based upon representations by any person other than Blue Cross and Blue Shield Health Plan of Georgia (Anthem) and that no person, entity, or organization other than Blue Cross and Blue Shield Health Plan of Georgia (Anthem) shall be held accountable or liable to the Employer for any of Blue Cross and Blue Shield Health Plan of Georgia's obligations to the Employer created under the contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Employer's Sole Discretion

The Employer, may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from us (the Claims Administrator), determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Form or Content of Benefit Booklet

No agent or employee of the Claims Administrator is authorized to change the form or content of this Benefit Booklet. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payer. If the Plan has duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to the Plan.

Medical Policy and Technology Assessment

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including the Claims Administrator's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payer, the benefits under this Plan do not duplicate any benefit for which Members are entitled to or enrolled in under Medicare, including Parts A and/or B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. If you do not enroll in Medicare Parts A and/or B when you are eligible, and Medicare would be primary (e.g., for Members in retiree plans or COBRA Members entitled to Medicare we will calculate benefits as if you had enrolled. Please refer to Medicare.gov for more details on when you should enroll.

Member Rights and Responsibilities

The delivery of quality healthcare requires cooperation between patients, their Providers and their healthcare benefit plans. One of the first steps is for patients and Providers to understand Member rights and responsibilities. Therefore, Anthem Blue Cross and Blue Shield has adopted a Members' Rights and Responsibilities statement.

It can be found on our website FAQs. To access, go to anthem.com and select Member Support. Under the Support column, select FAQs and your state, then the "Laws and Rights That Protect You" category. Then click on the "What are my rights as a member?" question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID card.

Modifications

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem or the Plan based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

We, on behalf of the Employer, pay In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Network Providers to us under the Program(s).

Policies, Procedures, and Pilot Programs

We, on behalf of the Employer, are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Administrative Services Agreement, we, on behalf of the Employer, have the authority, in our discretion, to institute from time to time, pilot or test programs for utilization management, care management, case management, clinical quality, disease management or wellness initiatives in certain designated geographic areas. These pilot initiatives are part of our ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan,

unless otherwise agreed to by the Employer. We reserve the right to discontinue a pilot initiative at any time without advance notice to Employer.

Program Incentives

We, on behalf of the Employer, may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. We may also offer, at our discretion, the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool, or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue a program or an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As the Claims Administrator of your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the Member Services number on the back of your Identification Card.

Relationship of Parties (Employer-Member-Anthem)

The Employer is fiduciary agent of the Member. Our notice to the Employer will constitute effective notice to the Member. It is the Employer’s duty to notify us of eligibility data in a timely manner. This Plan is not responsible for payment of Covered Services of Members if the Employer fails to provide us with timely notification of Member enrollments or terminations.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider’s Facilities.

Your In-Network Provider’s agreement for providing Covered Services may include financial incentives or risk sharing relationships related to the provision of services or referrals to other Providers, including In-Network Providers, Out-of-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

Reservation of Discretionary Authority

We, as the Claims Administrator, shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. We have complete discretion to interpret the Benefit Booklet. Our determination may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We, as the Claims Administrator, have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

The Claims Administrator reserves the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

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

Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Worker's Compensation or Employer Liability Law, the value of Covered Services shall be the amount paid for the Covered Services.

Voluntary Clinical Quality Programs

The Claims Administrator may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These

programs are not guaranteed and could be discontinued at any time. The Claims Administrator will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which the Claims Administrator encourages you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to test for immediate results or collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, please consult tax advisor.

Waiver

No agent or other person, except an authorized officer of the Employer, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Worker's Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Worker's Compensation Law. All money paid or owed by Worker's Compensation for services provided to you shall be paid back by, or on your behalf to the Plan if it has made payment for the services received. It is understood that coverage under this Plan does not replace or affect any Worker's Compensation coverage requirements.

Definitions

If a word or phrase in this Benefit Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Addictive Disease

A chronic, often relapsing, brain disease that causes compulsive alcohol or drug seeking and use despite harmful consequences to the individual who is addicted and to those around him or her.

Administrative Services Agreement

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

Ambulatory Surgery Center

A facility licensed as an Ambulatory Surgery Center as required by law that satisfies our accreditation requirements and is approved by us.

Appeals (Grievance)

Please see the "Your Right To Appeal" section).

Approved In-Network Provider

Please see the **"**Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" benefit in the "What's Covered" section.

Applied Behavior Analysis

The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that the Claims Administrator has agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim is a Surprise Billing Claim. Please see the "Claims Payment" section as well as the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details.

Behavioral Health Condition

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health condition or substance abuse disorder.

Benefit Booklet

This document (also called the Benefit Booklet), which describes the terms of your benefits. It is part of the Plan offered by your Employer.

Benefit Period

The length of time that the Plan will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period begins on your Plan's effective or renewal date and lasts for 12 months. The "Schedule of Benefits" shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The maximum amount that the Plan will pay for specific Covered Services during a Benefit Period.

Biomarker

A characteristic that is objectively measured and evaluated as an indicator of normal biologic processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to:

- known gene-drug interactions for medications being considered for use or already being administered;
- gene mutations and protein expression; and
- characteristics of genes.

Biomarker Testing

The analysis of a patient's tissue, blood, or other biospecimen for the presence of a Biomarker, including but not limited to single-analyte tests, multiplex panel tests, whole genome sequencing, protein expression, whole exome, and whole transcriptome.

Biosimilar/Biosimilars

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Brand Name Drug

Prescription Drugs that the Claims Administrator classifies as Brand Name Drugs or that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Medical Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have a Center of Medical Excellence Agreement with the Claims Administrator.

Chat Therapy

A synchronous text-message style communication session between a licensed Psychologist, Clinical Social Worker (L.C.S.W.), Marriage and Family Therapist (L.M.F.T.) or Professional Counselor (L.P.C.) and a patient that provides one-to-one virtual interactive counseling sessions. Each scheduled session lasts approximately one hour and can be accessed via a computer or mobile device using a secured platform arranged for by Anthem.

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Anthem Blue Cross and Blue Shield was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section).

Complications of Pregnancy

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

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

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

Consolidated Appropriations Act of 2021

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA), which are divided into five schedules.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services. See the "Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the "Schedule of Benefits" or the Maximum Allowed Amount.

Covered Procedure

Please see the **"**Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" benefit in the "What's Covered" section.

Covered Services

Health care services, supplies, or treatment described in this Benefit Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Benefit Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigative, excluded, or limited by this Benefit Booklet, or by any amendment or rider to this Benefit Booklet.
- Approved by the Claims Administrator before you get the service if prior authorization is needed.

A charge for a Covered Service will only apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the Facility.

Covered Services do not include services or supplies not described in the Provider records.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

1. Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
2. Changing dressings of non-infected wounds, after surgery or chronic conditions,
3. Preparing meals and/or special diets,
4. Feeding by utensil, tube, or gastrostomy,
5. Common skin and nail care,
6. Supervising medicine that you can take yourself,
7. Catheter care, general colostomy or ileostomy care,
8. Routine services which the Plan decides can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
9. Residential care and adult day care,
10. Protective and supportive care, including education,
11. Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as in a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

A Member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with the Claims Administrator or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the “What’s Covered” section.

Employee

A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with the Claims Administrator to administer this Plan.

Excluded Services (Exclusion)

Health care services your Plan doesn’t cover.

Experimental or Investigational

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

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medica (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t)(2) of the Social Security Act;
- The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
- It meets the following five technology assessment criteria:
  - The technology must have final approval from the appropriate government regulatory bodies.
  - The scientific evidence must permit conclusions concerning the effect of the technology of health outcomes.
  - The technology must improve the net health outcome.
  - The technology must be as beneficial as any established alternative.
  - The technology must be beneficial in practice.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Residential Treatment Center, or Skilled Nursing Facility as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by the Claims Administrator.

Fee(s)

The amount you must pay to be covered by this Plan.

Home Health Care Agency

A Provider licensed when required by law and approved by us, that:

1) Gives skilled nursing and other services on a visiting basis in your home; and
2) Supervises the delivery of such services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that must satisfy our accreditation requirements and be approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care

Identification Card (ID Card)

The card given to you that shows your Member identification, group numbers, and the Plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with the Claims Administrator, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see "How to Find a Provider in the Network" in the section "How Your Plan Works" for more information on how to find an In-Network Provider for this Plan.

Inpatient

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

Intensive In-Home Behavioral Health Program

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Late Enrollees

Employees or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the "Eligibility and Enrollment – Adding Members" section for further details.

Maintenance Medications

Please refer to the "Prescription Drug at a Retail or Home Delivery (Mail Order) Pharmacy" section for details.

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with the Claims Administrator's PBM to dispense a 90 day supply of Maintenance Medication.

Maximum Allowed Amount

The maximum payment that the Plan will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

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

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- compatible with the standards of acceptable medical practice in the United States;
- not provided solely for your convenience or the convenience of the Doctor, health care provider or Hospital;
- not primarily Custodial Care;
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis; and
- cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.

For purposes of treatment of ~~a~~ mental health and substance use disorder, Medically Necessary means a service or product addressing the specific needs of that patient for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with generally accepted standards of mental health or substance use disorder care;
- Clinically appropriate in terms of type, frequency, extent, site, and duration; and
- Not primarily for the economic benefit of Anthem and the Member or for the convenience of the patient, treating doctor, or other healthcare Provider.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Benefit Booklet.

Mental Health and Substance Use Disorder

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Mental Illness

A disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with the Claims, or the Claims Administrator's subcontractor(s), to give services to Members under this Plan.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does not include your Fees, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

The P&T process is a two-step process used to make determinations that will help you access quality, low-cost medicines within your Plan. This process first uses an independent P&T committee of pharmacists and physicians that evaluate the clinical Evidence of each product under review. During the second step of the process, a committee composed of members with various expertise combines the clinical review with an in-depth analysis of market dynamics, Member impact and financial value to make determinations about the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on the Claims Administrator's behalf. The Claims Administrator's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. The Claims Administrator's PBM, in consultation with the Claims Administrator, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor,
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan Administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Precertification

Please see the section "Getting Approval for Benefits" for details.

Predetermination

Please see the section "Getting Approval for Benefits" for details.

Prescription Drug (Drug)

A substance, that under the Federal Food, Drug & Cosmetic Act, must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1) Compounded (combination) medications, when all of the ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
2) Insulin, diabetic supplies, and syringes.

Prescription Order

A written request by a Provider, as permitted by law, for a Prescription Drug or medication, and each authorized refill.

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Prior Authorization

Please see the "Getting Approval for Benefits", "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy", and "Prescription Drugs Administered by a Medical Provider" sections for details.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, must satisfy our accreditation requirements and, for In-Network Providers, is approved by us. Details on our accreditation requirements can be found at https://www.anthem.com/provider/individu al-commercial/join-our-network. This includes any Provider that state law says we must cover when they give you services that state law

says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.
- For all other Surprise Billing Claims, the Recognized Amount is the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Referral

Please see the “How Your Plan Works” section for details.

Residential Treatment Center / Facility:

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorder conditions. The Facility must be licensed as a residential treatment center in the state in which it is located, satisfy our accreditation requirements, and be approved by us.

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and nurse practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Site of Service Provider

Site-of-Service (SOS) Providers are surgical, lab, radiology and diagnostic imaging centers that meet cost and other criteria established by Anthem. They are:

- A Provider that is not part of or owned by a Hospital and bills independently (i.e. not under a Hospital's name or ID number.) Providers such as Radiology Providers, Reference Laboratories, and Ambulatory Surgery Centers meet these criteria and are considered "freestanding" Site-of-Service Providers.
- An outpatient Facility location owned by a Hospital that is contracted with Anthem and meets the criteria to be considered "Site-of-Service" ("SOS").

These entities provide health care services such as surgery, laboratory tests, radiology and other services that are typically lower cost options for patients. Each participating Facility is subject to specific licensing, accreditation and credentialing requirements.

Skilled Nursing Facility

An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a skilled nursing facility in the state in which it is located, satisfy our accreditation requirements, and be approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician / Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee of the Employer who is eligible for and has enrolled in the Plan.

Surprise Billing Claim (Surprise Bill)

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vl có quyДn nhұn miДn phí thông tin này và sӧ trö giúp bҭng ngôn ngӳ cёa quý vl. Hãy gäi cho sæ Dlch Vө Thành Viên trên thҿ ID cёa quý vl ÿЏ ÿԝöc giúp ÿй. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(TTY/TDD: 711)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpáatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim jĊzyku. W tym celu skontaktuj siĊ z Dziaáem Obsáugi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

It's important we treat you fairly
We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.