

MEDICAL BENEFIT BOOKLET

For

DUBLIN CITY SCHOOLS

Effective Date: 1-1-2020

Administered By



Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If You need assistance in Spanish to understand this document, You may request it for free by calling Member Services at the number on Your Identification Card.

This Benefit Booklet provides You with 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 familiarize yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact Your Employer's Group Health Plan Administrator or call the Claims Administrator's Member Services Department.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The health care services are subject to the Limitations and Exclusions, Deductible and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Benefit Booklet.

Your Employer has agreed to be subject to the terms and conditions of Anthem's Provider agreements which may include precertification and utilization management requirements, timely filing limits, and other requirements to administer the benefits under this Plan.

Anthem Blue Cross and Blue Shield, or "Anthem" has been designated by Your Employer to provide administrative services for the Employer's Group Health Plan, such as claims processing, care management, and other services, and to arrange for a network of health care Providers whose services are covered by the Plan.

Important: This is not an insured benefit Plan. The benefits described in this Benefit 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.

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the state of Ohio. Although Anthem is the Claims Administrator and is licensed in Ohio, You will have access to Providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

Verification of Benefits

Verification of benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Member Services with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 7:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. **CALL THE MEMBER SERVICES NUMBER ON YOUR IDENTIFICATION CARD** or see the section titled **Health Care Management - Precertification** rules.

Identity Protection Services

Identity protection services are available with Your Employer's Anthem health plans. To learn more about these services, please visit www.anthem.com/resources.

MEMBER RIGHTS AND RESPONSIBILITIES.....	4
SCHEDULE OF BENEFITS	6
TOTAL HEALTH AND WELLNESS SOLUTION	14
ELIGIBILITY	17
HOW YOUR PLAN WORKS.....	20
HEALTH CARE MANAGEMENT - PRECERTIFICATION	22
BENEFITS	34
LIMITATIONS AND EXCLUSIONS	59
CLAIMS PAYMENT	62
YOUR RIGHT TO APPEAL	71
COORDINATION OF BENEFITS (COB)	79
SUBROGATION AND REIMBURSEMENT	84
GENERAL INFORMATION.....	86
WHEN COVERAGE TERMINATES.....	91
DEFINITIONS	95
HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW	108
IT'S IMPORTANT WE TREAT YOU FAIRLY	111
GET HELP IN YOUR LANGUAGE.....	112

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member You have rights and responsibilities when receiving health care. As Your health care partner, the Claims Administrator wants to make sure Your rights are respected while providing Your health benefits. That means giving You access to the Claims Administrator's network health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

- Speak freely and privately with Your health care Providers about all health care options and treatment needed for Your condition no matter what the cost or whether it is covered under Your Plan.
- Work with Your Doctors to make choices about Your health care.
- Be treated with respect and dignity.
- Expect the Claims Administrator to keep Your personal health information private by following the Claims Administrator's privacy policies, and state and Federal laws.
- Get the information You need to help make sure You get the most from Your health Plan, and share Your feedback. This includes information on:
 - The Claims Administrator's company and services
 - The Claims Administrator network of health care Providers.
 - Your rights and responsibilities.
 - The rules of Your health Plan.
 - The way Your health Plan works.
- Make a complaint or file an appeal about:
 - Your health Plan and any care You receive.
 - Any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care You may get in the future. This includes asking Your Doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health Plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give the Claims Administrator, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with the Plan.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

If You would like more information, have comments, or would like to contact the Claims Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your Identification Card.

The Claims Administrator wants to provide high quality customer service to our Members. Benefits and coverage for services given under the Plan are governed by the Employer's Plan and not by this **Member Rights and Responsibilities** statement.

How to Obtain Language Assistance

Anthem is committed to communicating with our Members about their health plan, regardless of their language. Anthem 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 assist You. Translation of written materials about Your benefits can also be requested 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.

SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the **Definitions** and **Claims Payment** sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are Your responsibility, such as Deductibles and/or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

Schedule of Benefits	Network	Out-of-Network
Calendar Year Deductible		
Individual	\$1,400	\$2,800
Family	\$2,800	\$5,600
Charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.		
All Covered Services are subject to the Deductible unless otherwise specified in this booklet.		
<p>Your Plan has a non-embedded Deductible which means:</p> <ul style="list-style-type: none"> • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If You also cover Dependents (other family members) under this Plan, only the "Family" amounts apply. The "Family" Deductible amounts can be satisfied by a family member or a combination of family members. Once the Family Deductible is met, it is considered met for all family members. 		
The Network and Out-of-Network calendar year Deductibles are separate and cannot be combined.		
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)		
Plan Pays	90%	70%
Member Pays	10%	30%
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		
Out-of-Pocket Maximum Per Calendar Year		
Includes Coinsurance and the calendar year Deductible.		
Does <u>NOT</u> include precertification penalties, Services deemed not Medically Necessary by medical management and/or Anthem, charges in excess of the Maximum Allowed Amount or Non-Covered Services.		

Schedule of Benefits	Network	Out-of-Network
Individual	\$2,600	\$5,200
Family	\$5,200	\$10,400
<p>Your Plan has a non-embedded Out-of-Pocket which means:</p> <ul style="list-style-type: none"> • If You, the Subscriber, are the only person covered by this Plan, only the “Individual” amounts apply to You. • If You also cover Dependents (other family members) under this Plan, the “Family” amounts apply. The “Family” Out-of-Pocket amounts can be satisfied by a family member or a combination of family members. Once the Family Out-of-Pocket is met, it is considered met for all family members. 		
<p>The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined.</p>		

Benefits	Member Responsibility	
	Network	Out-of-Network
Note: All Covered Services are subject to the Deductible unless otherwise specified in this booklet		
Allergy Care		
Testing and Treatment	10%	30%
Behavioral Health/Substance Abuse Care		
Hospital Inpatient Services	10%	30%
Outpatient Services	10%	30%
Physician Services (Home and Office Visits-Including Online Visits) and Intensive In-Home Behavioral Health Programs	10%	30%
Applied Behavioral Analysis (ABA) Therapy	10%	30%
Autism Services	10%	30%
Autism Maximums		
- Occupational Therapy	20 visits per Benefit Period, Network and Out-of-Network combined	
- Speech Therapy	20 visits per Benefit Period, Network and Out-of-Network combined	
- Clinical Therapeutic Intervention Services	20 hours per week, Network and Out-of-Network combined	
Note: Visit limits are separate from those listed in Outpatient Therapy Services.		

Benefits	Member Responsibility	
	Network	Out-of-Network
Note: All Covered Services are subject to the Deductible unless otherwise specified in this booklet		
Note: Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with Federal law.		
Clinical Trials See Clinical Trials under Benefits section for further information.	10%	30%
Dental, Oral Surgery and TMJ Services	10%	30%
Oral Surgery/TMJ excludes appliances and orthodontic treatment		
Diagnostic Services	10%	30%
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Emergency Room, Urgent Care, and Ambulance Services		
Emergency Room for an Emergency Medical Condition	10%	10% (See note below)
Use of the Emergency Room for Non-Emergency Medical Conditions	10%	30%
Urgent Care Clinic Visit for an Emergency Medical Condition	10%	10% (See note below)
Ambulance Services (when Medically Necessary) Land/Air	10%	10% (See note below)
Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		
Eye Care - Non-Routine	10%	30%
Office Visit – medical eye care exams (treatment of disease or Injury to the eye)		

Benefits	Member Responsibility	
	Network	Out-of-Network
Note: All Covered Services are subject to the Deductible unless otherwise specified in this booklet		
Gene Therapy Services • Precertification required	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Hearing Care - Non-Routine	10%	30%
Office Visit – Audiometric exam/hearing evaluation test		
Home Health Care Services	10%	30%
Maximum Home Care visits (does not apply to Private Duty Nursing benefit)	100 visits per calendar year Network and Out-of-Network combined	
Hospice Care Services	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Hospital Inpatient Services	10%	30%
Maternity Care & Other Reproductive Services		
Maternity Services	10%	30%
Note: Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified.		
Infertility Services – diagnosis only	10%	30%
Sterilization Services	10%	30%
Sterilizations for women will be covered under the “Preventive Services” benefit. Please see that section in Benefits for further details.		
Medical Supplies and Equipment		
Medical Supplies	10%	30%
Durable Medical Equipment	10%	30%
Orthotics Foot and shoe	10%	30%
Prosthetic Appliances (external)	10%	30%

Benefits	Member Responsibility	
	Network	Out-of-Network
Note: All Covered Services are subject to the Deductible unless otherwise specified in this booklet		
Nutritional Counseling	10%	30%
Maximum Visits	9 visits per calendar year Network and Out-of-Network combined	
Office Surgery	10%	30%
Online Visits (Other than Behavioral Health & Substance Abuse; see Behavioral Health/Substance Abuse Care section for further details)	10%	30%
Outpatient Hospital/Facility Services	10%	30%
Physician Services (Home and Office Visits)	10%	30%
Important Note on Office Visits at an Outpatient Facility: If you have an office visit with your Primary Care Physician or Specialty Care Physician at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under the "Outpatient Facility" section earlier in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
Preventive Services	0% (not subject to the deductible)	30%
Skilled Nursing Facility	10%	30%
Surgical Services	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Gastric Bypass/Obesity Surgery When Medically Necessary.		
Therapy Services (Outpatient)		
Physical Therapy	10%	30%
Occupational Therapy	10%	30%

Benefits	Member Responsibility	
	Network	Out-of-Network
Note: All Covered Services are subject to the Deductible unless otherwise specified in this booklet		
Speech Therapy	10%	30%
Cardiac Rehabilitation	10%	30%
Manipulation Therapy	10%	30%
Radiation Therapy	10%	30%
Chemotherapy	10%	30%
Respiratory Therapy	10%	30%
Vision Therapy	10%	30%
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		
Benefits for Physical Therapy are limited to 60 visits per calendar year, Network and Out-of-Network combined.		
Benefits for Occupational Therapy are limited to 30 visits per calendar year, Network and Out-of-Network combined.		
Benefits for Speech Therapy are limited to 20 visits per calendar year, Network and Out-of-Network combined.		
Benefits for Manipulation Therapy are limited to 20 visits per calendar year, Network and Out-of-Network combined.		
Transplants		
Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy.	Center of Excellence/Network Transplant Provider	Out-of-Network Transplant Provider
The Center of Excellence requirements do not apply to Cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.		
Note: Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.)		

Benefits	Member Responsibility	
	Network	Out-of-Network
Note: All Covered Services are subject to the Deductible unless otherwise specified in this booklet		
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Member Services number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)	Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.
Covered Transplant Procedure during the Transplant Benefit Period	10%	30%
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient)	10%	30%
Includes unrelated donor search up to \$30,000 per transplant.		
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)	10%	30%
Eligible Travel and Lodging	10%	30%
Limited to \$10,000 per Transplant maximum Network and Out-of-Network combined, subject to Claims Administrator's approval.		

Benefits	Network	Out-of-Network
Prescription Drugs		
Retail Pharmacy (31-day supply)		
• Tier 1	10%	Not Covered
• Tier 2	10%	Not Covered
• Tier 3	10%	Not Covered
• Tier 4	10%	Not Covered
Home Delivery (Mail Service) (90-day supply)		
• Tier 1	10%	Not Covered
• Tier 2	10%	Not Covered
• Tier 3	10%	Not Covered
• Tier 4	10%	Not Covered
<p>Note: The available day supply may be less than the 30 or 90 days shown above due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.</p>		
<p>Note: A limited number of Prescription Drugs require Prior Authorization for Medical Necessity. If Prior Authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires Prior Authorization, please call Member Services. If an Out-of-Network Pharmacy is used, the Member must file a claim for reimbursement; the Member may be responsible for the difference between the negotiated rate and the Pharmacy's actual charge.</p>		
<p>Note: Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Coinsurance when obtained from a Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if obtained from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Coinsurance.</p>		

TOTAL HEALTH AND WELLNESS SOLUTION

ComplexCare

The ComplexCare program reaches out to You if You are at risk for frequent and high levels of medical care in order to offer support and assistance in managing Your health care needs. ComplexCare empowers You for self-care of Your condition(s), while encouraging positive health behavior changes through ongoing interventions. ComplexCare nurses will work with You and Your Physician to offer:

- Personalized attention, goal planning, health and lifestyle coaching.
- Strategies to promote self-management skills and medication adherence.
- Resources to answer health-related questions for specific treatments.
- Access to other essential health care management programs.
- Coordination of care between multiple Providers and services.

The program helps You effectively manage Your health to achieve improved health status and quality of life, as well as decreased use of acute medical services.

ConditionCare Programs

ConditionCare programs help maximize Your health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult).
- Diabetes (pediatric and adult).
- Heart failure (HF).
- Coronary artery disease (CAD).
- Chronic obstructive pulmonary disease (COPD).

You will receive:

- 24/7 phone access to a nurse coach who can answer Your questions and give You up-to-date information about Your condition.
- A health review and follow-up calls if You need them.
- Tips on prevention and lifestyle choices to help You improve Your quality of life.

ConditionCare Support Programs

ConditionCare Support programs are designed to help You better manage the following conditions:

- Low Back Pain – focuses on disorders of the lumbar region.
- Musculoskeletal – addresses arthritis, osteoporosis and hip/knee replacements.
- Vascular At-Risk – targets hypertension, hyperlipidemia and metabolic syndrome as precursors of vascular diseases.

Future Moms

- The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches supported by pharmacists, registered dietitians, social workers and medical directors. You will receive:

- 24/7 phone access to a nurse coach who can talk with You about Your pregnancy and answer Your questions.
- *Your Pregnancy Week by Week*, a book to show You what changes You can expect for You and Your baby over the next nine months.
- Useful tools to help You, Your Physician and Your Future Moms nurse coach track Your pregnancy and spot possible risks.

24/7 NurseLine

You may have emergencies or questions for nurses around-the-clock. 24/7 NurseLine provides You with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, You can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team – RN license (BSN preferred) that helps Members assess systems, understand medical conditions, ensure Members receive the right care in the right setting and refer You to programs and tools appropriate to Your condition.
- Bilingual RNs, language line and hearing impaired services.
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics.
- Proactive callbacks within 24 to 48 hours for Members referred to 911 emergency services, poison control and pediatric Members with needs identified as either emergent or urgent.
- Referrals to relevant community resources.

Autism Spectrum Disorders (ASD) Program

The ASD Program is comprised of a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a Member who has a diagnosis of ASD. Anthem provides specialized case management services for Members with autism spectrum disorders and their families. The Program also includes precertification and Medical Necessity reviews for Applied Behavior Analysis, a treatment modality targeting the symptoms of autism spectrum disorders.

For families touched by ASD, Anthem's Autism Spectrum Disorders Program provides support for the entire family, giving assistance wherever possible and making it easier for them to understand and utilize care, resulting in access to better outcomes and more effective use of benefits. The ASD Program has three main components:

Education

- Educates and engages the family on available community resources, helping to create a system of care around the Member.
- Increases knowledge of the disorder, resources, and appropriate usage of benefits

Guidance

- Applied Behavior Analysis management, including clinical reviews by experienced licensed clinicians. Precertification delivers value, ensuring that the Member receives the right care, from the right Provider, at the right intensity.
- Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning, and referrals.
- Assure that parents and siblings have the best support to manage their own needs.

Coordination

- Enhanced Member experience and coordination of care.

- Assistance in exploration of medical services that may help the Member, including referrals to medical case management.
- Licensed Behavior Analysts and Program Managers provide support and act as a resource to the interdisciplinary team, helping them navigate and address the unique challenges facing families with an autistic child.

Anthem Health Guide

Anthem Health Guide provides You with enhanced member services support. You can contact a health guide with questions about benefits, programs for Your health, help scheduling doctor's appointments, comparing costs for procedures, and more. Health guides can connect You with knowledgeable health professionals to help You manage chronic conditions, deal with an illness, or provide support for emotional concerns like anxiety or depression. Reach out to Member Services and our health guides via phone, email, app, or even chat online.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep You and Your bank account healthier. Here's how it works: the Claims Administrator will review Your incoming health claims to see if the Plan can save You any money. The Claims Administrator can check to see what medications You are taking and alert Your Physician if the Claims Administrator spot a potential drug interaction. The Claims Administrator also keeps track of Your routine tests and checkups, reminding You to make these appointments by mailing You MyHealth Notes. MyHealth Notes summarize Your recent claims. From time to time, the Claims Administrator will offer tips to save You money on Prescription Drugs and other health care supplies.

ELIGIBILITY

Members who do not enroll within 31 days of being eligible are considered Late Enrollees. Please refer to the “Late Enrollees” provision in this section.

Coverage for the Employee

This Benefit Booklet describes the benefits an Employee may receive under this health care Plan. The Employee is also called a Subscriber.

Coverage for the Employee’s Dependents

If the Employee is covered by this Plan, the Employee may enroll his or her eligible Dependents. Covered Dependents are also called Members.

Eligible Dependents Include:

- The Employee’s Spouse. For information on spousal eligibility please contact the Employer.
- The Employee’s dependent children until the end of the month they attain age 26, legally adopted children from the date the Employee assumes legal responsibility, foster children that live with the Employee and for whom the Employee is the primary source of financial support, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee’s children (or children of the Employee’s Spouse) for whom the Employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically impaired and totally dependent on the Employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the impairment is required within 31 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically. You must notify the Claims Administrator and/or the Employer if the Dependent’s marital or tax exemption status changes and they are no longer eligible for continued coverage.

Initial Enrollees

Initial Enrollees and eligible Dependents who were previously enrolled under group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage. Coverage will be effective based on the waiting period chosen by the Employer, and will not exceed 90 days.

New Hires

Applications for enrollment must be submitted within 31 days from the date an Employee is eligible to enroll as set by the Employer. Applications for membership may be obtained from the Employer. Coverage will be effective based on the waiting period chosen by the Employer and will not exceed 90 days. If the Employee or the Employee’s Dependents do not enroll when first eligible, the Employee or the Employee’s Dependents will be treated as Late Enrollees. Please refer to the “Late Enrollees” provision listed below.

Late Enrollees

If the Employee or the Employee’s Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, the Employee or the Employee’s Dependents may be eligible for special enrollment as set out below.

Special Enrollment Periods

If an Employee or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan **Standard** prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Employee or Dependent must request Special Enrollment within 31 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 stopped receiving group contributions toward the cost of the prior health plan;
- lost Employer contributions towards the cost of the other coverage; or
- are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes About Special Enrollment:

- Individuals enrolled during Special Enrollment periods are **not** Late Enrollees.
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and CHIP Special Enrollment/Special Enrollees

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

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

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

When Coverage Begins

If the Employee applies for coverage when first eligible, coverage will be effective on the date the Employer's length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires and will not exceed 90 days.

Changing Coverage

There may be an annual re-enrollment period during which time Members may elect to change their options.

Types of Coverage

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

Changing Coverage (Adding a Dependent)

You may add new Dependents to Your Plan by contacting Your Plan Administrator. The Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Employee has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

Marriage and Stepchildren

An Employee may add a Spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage.

If an Employee does not apply for coverage to add a Spouse and stepchildren within 31 days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the "Late Enrollees" provision in this section.

Newborn and Adopted Children

You must contact Your Employer within 31 days to add a newborn or adopted child.

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.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:

- an adopted child, regardless of whether or not the adoption has become final. An “adopted child” is any person under the age of 18 as of the date of adoption or placement for adoption. “Placement for adoption” means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
- a child for whom an Employee has received an MCSO (a “Medical Child Support Order”) which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order (“QMCSO”). Upon receipt of a QMCSO, the Employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Family and Medical Leave

If a covered Employee ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Changing Coverage or Removing a Dependent

When any of the following events occur, notify the Employer and ask for appropriate forms to complete:

- divorce;
- death of an enrolled family Member (a different type of coverage may be necessary);
- Dependent child reaches age 26 (see **When Coverage Terminates**); or
- Enrolled Dependent child becomes totally or permanently disabled.

Employee Not Actively at Work

Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Employer but not currently active due to health status.

HOW YOUR PLAN WORKS

Note: Capitalized terms such as Covered Services, Medical Necessity, and Out-of-Pocket Maximum are defined in the **Definitions** Section.

Introduction

Your health Plan is a Preferred Provider Organization (PPO) which is a comprehensive Plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

Network Services

When You use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has the final authority to decide the Medical Necessity of the service.

Network Providers include Primary Care Physicians/Providers (PCPs), Specialists (Specialty Care Physicians/Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for You. Referrals are never needed to visit a 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.

For services from Network Providers:

1. You will not need to file claims. Network Providers will file claims for Covered Services for You. (You will still need to pay any Coinsurance and/or Deductibles that apply.) You may be billed by Your Network Provider(s) for any Non-Covered Services You get or when You have not followed the terms of this Benefit Booklet.
2. Precertification will be done by the Network Provider. (See the **Health Care Management – Precertification** section for further details.)

Please read 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 the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services

When You do not use a 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:

- 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;
- You may have higher cost sharing amounts (i.e., Deductibles and/or Coinsurance);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see **Health Care Management – Precertification** for more details.)

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 Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's Network.
- Call Member Services to ask for a list of doctors and Providers that participate in this Plan's Network, based on specialty and geographic area.
- Check with Your doctor or Provider.

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 us to help with Your needs.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates 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.

Calendar Year Deductible

Before the Plan begins to pay benefits You must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the **Schedule of Benefits**. Deductible requirements are stated in the **Schedule of Benefits**.

HEALTH CARE MANAGEMENT - PRECERTIFICATION

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.

Acute Care at Home Programs

Anthem has programs available that offer acute care to Members where they live as an alternative to staying in a Facility, when the Member's condition and the Covered Services to be delivered, are appropriate for the home setting. We refer to these programs as Acute Care at Home Programs. These programs provide care for active, short-term treatment of a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. Acute care services are generally delivered by teams of health care Providers from a range of medical and surgical specialties. The Acute Care at Home Programs are separate from our Home Care Services benefit, are only available in certain Service Areas, and are only provided if the Member's home meets accessibility requirements.

Covered Services provided by Acute Care at Home Programs may include Physician services (either in-person or via telemedicine), diagnostic services, surgery, home care services, home infusion therapy, Prescription Drugs Administered by a Medical Provider, therapy services, and follow-up care in the community. Prescription Drugs at a Retail or Mail Order Pharmacy are not included in these Programs. Benefits for those Drugs are described under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section. Acute Care at Home Programs may also include services required to set up telemedicine technology for in-home patient monitoring, and may include coverage for meals.

Members who qualify for these programs will be contacted by our Provider, who will discuss how treatment will be structured, and what costs may be required for the services. Benefit limits that might otherwise apply to outpatient or home care services, (e.g., home care visits, physical therapy, etc.), may not apply to these programs.

Your participation in these programs is voluntary. If You choose to participate, Your Provider will discuss the length of time that benefits are available under the program (e.g., the Acute Care at Home Benefit Period) when You enroll. The Acute Care at Home Benefit Period typically begins on the date Your Acute Care at Home Provider sets up services in Your home, and lasts until the date You are discharged from the Program.

Any Covered Services received before or after the Acute Care at Home Benefit Period will be covered according to the other benefits of this Plan.

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. The Plan 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 telephone number on Your Identification Card or visit www.anthem.com.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if the Plan decides 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 no later than 2 business days after admission or as soon as possible within a reasonable period of time. 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. An example of a type of post-service review is a retrospective post-claim review. For retrospective reviews if you send a written request, the Plan will permit a retrospective review for a claim that is submitted where prior authorization was required but not obtained if the service in question meets all of the following:
 - a. The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
 - b. The new service was not known to be needed at the time the original prior authorized service was performed.
 - c. The need for the new service was revealed at the time the original authorized service was performed.

Once the Plan receives the written request and all necessary information the Claims Administrator will review the claim for coverage and Medical Necessity. The Plan will not deny a claim for the new service based solely on the fact that the Claims Administrator did not receive a prior authorization approval for the new service in question.

Failure to Obtain Precertification Penalty:

IMPORTANT NOTE: IF YOU OR YOUR NON NETWORK PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, A \$300 PENALTY WILL APPLY AND YOUR OUT-OF-POCKET COSTS WILL INCREASE. THIS DOES NOT APPLY TO MEDICALLY NECESSARY SERVICES FROM A NETWORK OR BLUECARD PROVIDER.

The following list is not all inclusive and is subject to change; please call the Member Services telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.

Inpatient Admission:

- Acute Inpatient
- Acute Rehabilitation
- LTACH (Long Term Acute Care Hospital)

- Skilled Nursing Facility
- OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)
- Emergency Admissions (Requires Plan notification no later than 2 business days after admission)

Diagnostic Testing:

- Cardiac Ion Channel Genetic Testing
- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Genetic Testing for Breast and/or Ovarian Cancer Syndrome
- Preimplantation Genetic Diagnosis Testing
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders
- Prostate Saturation Biopsy

Durable Medical Equipment (DME)/Prosthetics:

- Augmentative and Alternative Communication (AAC) Devices/ Speech Generating Devices (SGD)
- Dynamic Low-Load Prolonged-Duration Stretch Devices
- Electrical Bone Growth Stimulation
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
- Implantable Infusion Pumps
- Lower Limb Prosthesis and Microprocessor Controlled Lower Limb Prosthesis
- Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
- Ultrasound Bone Growth Stimulation
- Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)
- Prosthetics: Electronic or externally powered and select other prosthetics- (myoelectric-UE)
- Standing Frame

Gender Reassignment Surgery

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
 - ▶ Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
 - ▶ Donor Leukocyte Infusion
- Axicabtagene ciloleucel (Yescarta™) (CAR) T-cell immunotherapy treatment
- Tisagenlecleucel (Kymriah™) (CAR) T-cell immunotherapy treatment
- Gene replacement therapy intended to treat retinal dystrophies
- Intrathecal treatment of Spinal Muscular Atrophy (SMA)

Outpatient and Surgical Services:

- Air Ambulance (excludes 911 initiated emergency transport)
- Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Balloon and Self-Expanding Absorptive Sinus Ostial Dilation
- Bariatric Surgery and Other Treatments for Clinically Severe Obesity
- Bone-Anchored and Bone Conduction Hearing Aids
- Bronchial Thermoplasty for Treatment of Asthma

Cardio-Vascular

- ▶ Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- ▶ Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- ▶ Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
- ▶ Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- ▶ Implantable or Wearable Cardioverter-Defibrillator
- ▶ Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- ▶ Mechanical Embolectomy for Treatment of Acute Stroke
- ▶ Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- ▶ Partial Left Ventriculectomy
- ▶ Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation (Radiofrequency and Cryoablation)
- ▶ Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- ▶ Transcatheter Heart Valve Procedures
- ▶ Transmyocardial/Periventricular Device Closure of Ventricular Septal Defects
- ▶ Treatment of Varicose Veins (Lower Extremities)
- ▶ Venous Angioplasty with or without Stent Placement/ Venous Stenting
- Cochlear Implants and Auditory Brainstem Implants
- Corneal Collagen Cross-Linking
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation pacing systems
- Electric Tumor Treatment Field (TTF) for treatment of glioblastoma
- Functional Endoscopic Sinus Surgery
- Immunoprophylaxis for respiratory syncytial virus (RSV)
- Implantable Middle Ear Hearing Aids
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Lumbar Discography
- Lung Volume Reduction Surgery
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)

Musculo-Skeletal Surgeries

- ▶ Axial Lumbar Interbody Fusion

- ▶ Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- ▶ Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- ▶ Implanted Devices for Spinal Stenosis
- ▶ Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- ▶ Lysis of Epidural Adhesions
- ▶ Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- ▶ Meniscal Allograft Transplantation of the Knee
- ▶ Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- ▶ Sacroiliac Joint Fusion
- ▶ Total Ankle Replacement
- ▶ Treatment of Osteochondral Defects of the Knee and Ankle
- Occipital nerve stimulation
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Perirectal Spacers for Use During Prostate Radiotherapy (Space Oar)
- Private Duty Nursing
- Presbyopia and Astigmatism-Correcting Intraocular Lenses

Plastic/Reconstructive Surgeries/ Treatments:

- ▶ Abdominoplasty ,Panniculectomy, Diastasis Recti Repair
- ▶ Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting Hyperbaric Oxygen Therapy (Systemic/Topical)
- ▶ Blepharoplasty
- ▶ Brachioplasty
- ▶ Breast Procedures; including Reconstructive Surgery, Implants and other Breast Procedures
- ▶ Chin Implant, Mentoplasty, Osteoplasty Mandible
- ▶ Insertion/injection of prosthetic material collagen implants
- ▶ Liposuction/lipectomy
- ▶ Mandibular/Maxillary (Orthognathic) Surgery
- ▶ Mastectomy for Gynecomastia
- ▶ Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- ▶ Penile Prosthesis Implantation
- ▶ Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
- ▶ Procedures Performed on Male or Female Genitalia
- ▶ Procedures Performed on the Trunk and Groin
- ▶ Reduction Mammoplasty
- ▶ Repair of pectus excavatum/carinatum
- ▶ Skin-Related Procedures
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Surgical and Ablative Treatments for Chronic Headaches
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions

- Surgical Treatment of Obstructive Sleep Apnea and Snoring
- Transanal Hemorrhoidal Dearterialization (THD)
- Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia
- Treatment of Hyperhidrosis
- Treatments for Urinary Incontinence
- Transcatheter Uterine Artery Embolization
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Viscocanalostomy and Canaloplasty

Radiation Therapy/Radiology Services:

- Intensity Modulated Radiation Therapy (IMRT)
- Magnetic Source Imaging and Magnetoencephalography (MSI/MEG)
- Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
- Proton Beam Therapy
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for treating Primary or Metastatic Liver Tumors
- Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Malignant Lesions Outside the Liver- except CNS and Spinal Cord
- Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule

Out-of-Network Referrals:

Out-of-Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or medical necessity.)

Mental Health/Substance Abuse (MHSA):

Pre-Certification Required

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Employer Group Custom Coverage Decision
 - ▶ Intensive Outpatient Therapy (IOP)
 - ▶ Partial Hospitalization (PHP)
- Residential Care
- Behavioral Health in-home Programs

The following services do not require precertification, but are recommended for pre-determination of Medical Necessity due to the existence of post service claim review criteria and/or the potential cost of services to the Member if denied by for lack of Medical Necessity: Procedures and/or equipment which have Medically Necessary criteria determined by the Claims Administrator’s Medical Policy or Clinical Guidelines.

The ordering Provider, Facility or attending Physician should contact the Claims Administrator to request a Precertification or Predetermination review (“requesting Provider”). 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
Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Anthem Blue Cross Blue Shield (GA); and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company.	Provider	<ul style="list-style-type: none"> The Provider must get Precertification when required
Out-of-Network/ Non-Participating	Member	<ul style="list-style-type: none"> 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.
Blue Card Provider outside the service areas of the states listed in the column above and BlueCard Providers in other states not listed,	Member (Except for Inpatient Admissions)	<ul style="list-style-type: none"> 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. Blue Card Providers must obtain precertification for all Inpatient Admissions.
<p>NOTE: For an Emergency Care admission, precertification is not required. However, You, Your authorized representative or Doctor must tell the Claims Administrator no later than 2 business days after admission or as soon as possible within a reasonable period of time.</p>		

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 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. The timeframes and requirements listed are based on Federal laws. You may call the phone number on the back of Your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 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	15 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 of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required timeframe, the Claims Administrator will make a decision based upon the information it has.

The Claims Administrator will notify You and Your Provider 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.

Once a pre-service review is approved, it will not be retroactively denied, except in cases of fraudulent or materially incorrect information, when all of the following are met:

- The Provider submits a prior authorization request to the Claims Administrator for a health care service, drug, or device;
- The Plan approves the prior authorization request after determining that all of the following are true:
 1. The patient is eligible under this Plan.
 2. The health care service, drug, or device is covered under this Plan.
 3. The health care service, drug, or device meets our standards for Medical Necessity and prior authorization.
- The Provider renders the health care service, drug, or device pursuant to the approved prior authorization request and all of the terms and conditions of the Provider’s contract with the Claims Administrator;
- On the date the health care practitioner renders the prior approved health care service, drug, or device, all of the following are true:
 1. The patient is eligible under this Plan.
 2. The patient's condition or circumstances related to their care has not changed.
 3. The Provider submits an accurate claim that matches the information submitted by the Provider in the approved prior authorization request.

- If the Provider submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the Provider in the approved prior authorization request, upon receiving a denial of services from the Plan, the Provider may resubmit the claim with the information that matches the information included in the approved prior authorization.

Electronic Submission of Pre-service reviews

If the request for a Pre-service Review of a health care service, device, or drug is submitted to the Claims Administrator electronically from your Provider, the Plan will respond:

- Within forty-eight (48) hours of the time the request is received if it's for Urgent Care Services;
- Within ten (10) calendar days of the time the request is received if it's for non Emergency or non-Urgent Care Services.

The Plan's response will state if the request is approved or denied. If denied, the Plan will provide the specific reason for the denial. If incomplete, the Plan will indicate the specific additional information that is required to process the request. If the Claims Administrator requests additional information required to process the request, your Provider must provide an electronic receipt to the Claims Administrator acknowledging that the request for additional information was received.

Please note that the appeals procedures under the **Your Right to Appeal** section of this Benefit Booklet are also available under this option.

For purposes of this section only, Urgent Care Services means medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
- In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of a Pre service Review request as outlined in the **Health Care Management - Precertification** section of this Plan.

This section does not apply to Emergency services.

Important Information

From time to time certain medical management processes (including utilization management, case management, and disease management) may be waived, enhanced, changed or ended. An alternate benefit may be offered if in the Plan's sole 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

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

The Claims Administrator's 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, the Claims Administrator will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers.

In addition, the Claims Administrator 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. The Claims Administrator will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if at the Claims Administrator's discretion the alternate or extended benefit is in the best interest of You and the Plan 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, the Claims Administrator will notify You or Your authorized representative in writing.

BENEFITS

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details. All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.

Ambulance Service

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 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 a Network Hospital
 - Between a Hospital and a 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 a Network Hospital
 - Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. 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 the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's Maximum Allowed Amount.

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 Physician are not a Covered Service.

Other non-covered Ambulance Services include, but are not limited to, trips to:

- a Physician's office or clinic; or
- 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.**

Assistant Surgery

Services rendered by an assistant surgeon are covered based on Medical Necessity.

Behavioral Health Care and Substance Abuse Treatment

See the **Schedule of Benefits** for any applicable Deductible and/or Coinsurance information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or outpatient basis will not be subject to Deductibles and/or Coinsurance provisions that are less favorable than the Deductibles and/or Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Covered Services include the following:

- **ABA Therapy** - Medically Necessary applied behavioral analysis services.
- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
 - observation and assessment by a psychiatrist weekly or more often; and
 - rehabilitation, therapy, and education.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs and (when available in Your area) Intensive In-Home Behavioral Health Programs.
- **Online Visits** when available in Your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits 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 doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Examples of Providers from whom You can receive Covered Services include:

- Psychiatrist;
- Psychologist;
- 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 by the state to give these services, when they have to be covered by law.

Members with mental health or substance abuse conditions (including opioid-use disorders) have access to individual case management programs as detailed under “Health Plan Individual Case Management” in the section **Health Care Management - Precertification**. These programs include coordination of services for high risk Members with opioid-use disorder or opioid disorders. Also, refer to the **Health Care Management - Precertification** section for any Precertification and review requirements. This section defines what services, which include treatment of opioid abuse, qualify for an urgent review based on state and Federal laws. To get additional information for opioid education and related issues please go to www.anthem.com and enter “opioid” in the search box.

Autism Services

Covered Services include, but are not limited to, benefits for children (ages 0 to 14) with a medical diagnosis of autism spectrum disorder for:

- Outpatient Physical Rehabilitation services including:
 1. Speech and Language therapy and/or Occupational therapy, performed by a licensed therapists, limited to the visits shown in the **Schedule of Benefits**; and
 2. Clinical Therapeutic Intervention defined as therapies supported by empirical (factual) evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of the state of Ohio to perform the services in accordance with a treatment plan, limited to 20 hours per week.
 3. Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment.

Coverage provided under this section is contingent upon both of the following:

- The Member receiving prior authorization for the services;
- The services being prescribed or ordered by either a developmental pediatrician or a psychologist trained in autism.

Except for Inpatient Services, if a Member is receiving treatment for an autism spectrum disorder, We may review the treatment plan annually, unless We and the Member’s treating physician or psychologist agree that a more frequent review is necessary. Any agreement shall apply only to a particular Member being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism spectrum disorder by a physician or psychologist. We will cover the cost of obtaining any review or treatment plan.

Breast Cancer Care

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with

the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

Breast Reconstructive Surgery

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Cardiac Rehabilitation

Covered Services are provided as outlined in the **Schedule of Benefits**.

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.
3. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
4. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require You to use a 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 other requests for clinical trials services, including requests 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. The Plan reserves its right to exclude any of the following services:

1. The Experimental/Investigative item, device, or service; or
2. Items and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

Staff consultations required by Hospital rules are excluded. Referrals (the transfer of a patient from one Physician to another for treatment) are not consultations under this Plan.

Dental Services

Related to Accidental Injury

Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

Other Dental Services

Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- the Member is under the age of five (5);
- the Member has a severe impairment that requires hospitalization or general anesthesia for dental care; or
- the Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes

Equipment and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Services."

Dialysis Treatment

The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

Durable Medical Equipment

The Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- it can stand repeated use;
- it is manufactured solely to serve a medical purpose;
- it is not merely for comfort or convenience;
- it is normally not useful to a person not ill or Injured;
- it is ordered by a Physician;

- the Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item; and
- it is related to the Member's physical disorder.

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. 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 that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Emergency Care and Urgent Care Services

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which the Claims Administrator determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Out-of-Network Provider.

Emergency Care rendered by an Out-of-Network Provider will be covered as a Network service, however the Member **may** be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Coinsurance and/or Deductible. An Out-of-Network Provider of Emergency Services may send you a bill for any charges remaining after your Plan has paid (this is called "balance billing").

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method the Claims Administrator generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include Facility costs and Physician services, and supplies and Prescription Drugs charged by that Facility.

Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from an Out-of-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as an Out-of-Network service unless the Claims Administrator authorizes the continuation of care and it is Medically Necessary.

Gene Therapy Services

Your Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification. See **Health Care Management** - Precertification for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is a Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call us to find out which

providers are approved Providers. (When calling Member Services, ask for the transplant case manager for further details.)

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

- a. Services determined to be Experimental/Investigational;
- b. Services provided by a non-approved Provider or at a non-approved Facility; or
- c. Services not approved in advance through Precertification.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
 - injection or inhalation of a drug or other agent (local infiltration is excluded).
- Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

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.

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Member must be essentially confined at home.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

- When available in Your area, benefits are also available for intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are stated in the “Behavioral Health Care and Substance Abuse Treatment” section.

Covered Services for Home Health Care do not include:

- food, housing, homemaker services, sitters, home-delivered meals;
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care;
- services and/or supplies which are not included in the Home Health Care plan as described;
- services of a person who ordinarily resides in the Member’s home or is a member of the family of either the Member or Member’s Spouse;
- any services for any period during which the Member is not under the continuing care of a Physician;
- convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member;
- any services or supplies not specifically listed as Covered Services;
- routine care and/or examination of a newborn child;
- dietician services;
- maintenance therapy;
- dialysis treatment; or
- purchase or rental of dialysis equipment.

Hospice Care Services

You are eligible for Hospice care if Your Doctor and the Hospice medical director certify that You are terminally ill and likely to 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:

- care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- social services and counseling services from a licensed social worker;
- nutritional support such as intravenous feeding and feeding tubes;
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies; and
- 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 care giver and individuals with significant personal ties for one year after the Member’s death.

Your Physician must agree to care by the Hospice and must be consulted in the development of the care 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 Benefit Booklet.

Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

Network

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

- Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **Schedule of Benefits** section.

Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

Human Organ and Tissue Transplant Services

Notification

To maximize Your benefits, You need to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.

Contact the Member Services telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or Benefit Booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered 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 Network Transplant Provider agreement. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

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

Prior Approval and Precertification

In order to maximize Your benefits, the Claims Administrator strongly encourages You to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Member Services telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Claims Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. 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 a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the Facility where Your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the Facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Licensed Speech Therapist Services

Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits**. Speech therapy is not covered when rendered for the treatment of Developmental Delay.

Maternity Care and Reproductive Health Services

Covered Services are provided for Network Maternity Care as stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See "Changing Coverage (Adding a Dependent)" to add a newborn to Your coverage.)

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member's attending Physician.

Abortion (Therapeutic)

Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape.

Contraceptive Benefits

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

Infertility Services

Your Plan also includes benefits for the diagnosis of Infertility.

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 Services" benefit.

Medical Care

General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

Nutritional Counseling

Nutritional counseling related to the medical management of a disease state as stated in the **Schedule of Benefits**.

Obesity

Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan.

Out-of-Network Freestanding Ambulatory Facility

Any services rendered or supplies provided while You are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

Out-of-Network Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **Schedule of Benefits** section.

Online Visits

When available in Your area, Your coverage will include online visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See **Schedule of Benefits** for any applicable Deductible, Coinsurance and benefit limitation information. For Behavioral Health and Substance Abuse Online Visits, see the "Behavioral Health Care and Substance Abuse Treatment" section. Non-Covered Services include, but are not limited to, communications used for:

- reporting normal lab or other test results;

- office appointment requests;
- billing, insurance coverage or payment questions;
- requests for referrals to Physicians outside of the online care panel;
- benefit precertification; and
- Physician to Physician consultation.

Oral Surgery

Covered Services include only the following:

- Fracture of facial bones;
- Removal of impacted teeth;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan and performed within the timeframes shown in the **Schedule of Benefits** after the accident.

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:

- 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.

Other Covered Services

Your Plan provides Covered Services when the following services are Medically Necessary:

- chemotherapy and radioisotope, radiation and nuclear medicine therapy;
- diagnostic x-ray and laboratory procedures;
- dressings, splints and casts when provided by a Physician;
- oxygen, blood and components, and administration;
- pacemakers and electrodes; or
- use of operating and treatment rooms and equipment.

Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

Outpatient Hospital Services

The Plan provides Covered Services when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

Outpatient Surgery

Network Hospital outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services”.

Physical Therapy, Occupational Therapy, Manipulation Therapy

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the **Schedule of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. No coverage is available when such services are necessitated by Developmental Delay.

Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements. Consultations between your Primary Care Physician and a Specialty Care Physician are included, when approved by Anthem.

Preventive Services

Preventive Services include screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA). This means many preventive care services are covered with no Deductible and/or Coinsurance when You use a Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under diagnostic services instead of this benefit, if the coverage does not fall within 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 of these services are screenings for:
 - a. breast cancer;
 - b. cervical cancer;
 - c. colorectal cancer;
 - 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 provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
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 procedures, and counseling. This includes Generic oral contraceptives and single-source Brand Name Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants

are also covered. Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to Your attending Provider, otherwise they will be covered under the "**Error! Reference source not found.**"

- b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
- c. Gestational diabetes screening.

Preventive care services for 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; and
 - 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.
5. 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.

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

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

- Routine screening mammograms. The total benefit for a screening mammography under this Plan, regardless of the number of claims submitted by Providers, will not exceed one hundred thirty per cent (130%) of the Medicare reimbursement rate in the state of Ohio for a screening mammography. If a Provider, Hospital, or other health care Facility provides a service that is a component of the screening mammography and submits a separate claim for that component, a separate payment shall be made to the Provider, Hospital, or other health care Facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. The benefit paid for mammography constitutes full payment under this Certificate. No Provider, Hospital, or other health care Facility shall seek or receive compensation in excess of the payment made that corresponds to the ratio paid by Medicare in Ohio.
- Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test).
- Child health supervision services from the moment of birth until age nine. Child health supervision services mean periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of hearing screening, by an individual acting in accordance with Ohio law. Periodic review means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

You may call Member Services using the number on Your Identification Card for additional information about these services or view the Federal government's web sites,

<http://www.healthcare.gov/center/regulations/prevention.html>, <http://www.ahrq.gov>, and <http://www.cdc.gov/vaccines/acip/index.html>.)

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth (except to correct traumatic Injuries); electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

Reconstructive Surgery

Benefits include reconstructive surgery 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. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

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

Retail Health Clinic

Benefits are provided for Covered Services received at a Retail Health Clinic.

Skilled Nursing Facility Care

Benefits are provided as outlined in the **Schedule of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or Facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member’s residence.

Covered Services include:

- semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- use of special care rooms;
- pathology and radiology;
- Physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician’s continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- a Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- no specific medical conditions exist that require care in a Skilled Nursing Facility; or
- the care rendered is for other than Skilled Convalescent Care.

Surgical Care

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

Treatment of Accidental Injury in a Physician's Office

All outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit if services are rendered by a Network Provider. Services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

Prescription Drug Benefits at a Retail or Home Delivery (Mail Service) Pharmacy

See the Schedule of Benefits for any applicable Deductible, Coinsurance and Benefit Limitation information.

Your plan also includes benefits for Prescription Drugs You get at a Retail or Mail Order Pharmacy. The Pharmacy benefits available to You under this Plan are managed by the Claims Administrator's Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which the Claims Administrator contracts to manage Your Pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Home Delivery (Mail Service) Pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating the covered Prescription Drug list (also known as a Formulary) establishing a network of retail pharmacies and operating a Home Delivery (Mail Service) Pharmacy. The PBM, in consultation with the Claims Administrator also provides services to promote and enforce the appropriate use of Pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

Important Note on Prohibited Pharmacy Benefit Practices:

- We will not directly or indirectly restrict You from being informed about less expensive ways to purchase Prescription Drugs.
- We cannot require a cost-share that is greater than the amount You would pay for a prescription drug if the drug were purchased without coverage under a health benefit plan.

You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on Your Identification Card. 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.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Claims Administrator can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity, and/or age limits established by the Plan or utilization guidelines.

Prescription Drug benefits may require prior authorization to determine if Your Drugs should be covered. Your Network Pharmacist will be told if Prior Authorization is required and if any additional details are needed for the Plan 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).
- Coverage of an opioid analgesic prescribed for the treatment of chronic pain, except when the drug is prescribed to you under one of the following circumstances:
 1. If you are a hospice patient in a hospice care program;
 2. If you are diagnosed with a terminal condition but are not a hospice patient in a hospice care program;
 3. If you have cancer or another condition associated with your cancer or history of cancer.

Step Therapy Protocol Exemption Process

If You or Your Doctor want to request an exemption for a Prescription Drug not recommended according to a step therapy protocol, You, Your Doctor, or Your pharmacist can get in touch with us by calling the Member Services number on Your Identification Card or by visiting [www.anthem.com]. We will provide, a copy of the procedures for requesting a protocol exemption.

Upon receipt of Your protocol exception request or Your appeal of a denial of a protocol exception request, We will review not more than:

- Forty-eight (48) hours after receiving the request or appeal for Urgent Care Services; or
- Ten (10) calendar days after receiving the request or appeal for non-urgent care situations.

Please note that an appeal shall be considered an Internal Appeal as discussed in the Appeals Procedures under the Grievance and External Review Procedures section of this Booklet are also available under this option. If the appeal does not resolve the disagreement, either Your or Your authorized representative may request an External Review as described under the Grievance and External Review Procedures section of this Booklet.

We will approve Your step therapy exemption request if any of the following are met:

- The required prescription drug is contraindicated for You, pursuant to the drug's United States food and drug administration prescribing information.
- You have tried the required Prescription Drug while under Your current, or a previous, health benefit plan, or another United States food and drug administration approved AB-rated Prescription Drug, and such Prescription Drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

- You are stable on a Prescription Drug selected by the Your health care provider for the medical condition under consideration, regardless of whether or not the Drug was prescribed when You were covered under the current or a previous health benefit plan, or have already gone through a step therapy protocol. However, we may require a stable patient to try a pharmaceutical alternative, per the Federal food and drug administration's orange book, purple book, or their successors, prior to providing coverage for the Prescribed Drug.

This process does not prevent either of the following:

- From us requiring You to try any new or existing pharmaceutical alternative, per the Federal Food and Drug Administration's orange book, purple book, or their successors, prior to providing or renewing coverage for the prescribed Drug;
- A health care provider from prescribing a Prescription Drug, consistent with medical or scientific evidence.

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 Claims Administrator's 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.

The Plan may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in its sole 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 Benefit Booklet.

For a prior approval related to a chronic condition, the Plan will honor a prior authorization approval for an approved drug for the lesser of the following from the date of the approval:

- Twelve months;
- the last day of your eligibility under this Plan.

For purposes of this section "chronic condition" means a medical condition that has persisted after reasonable efforts have been made to relieve or cure its cause and has continued, either continuously or episodically, for longer than six continuous months.

The twelve-month approval is no longer valid and automatically terminates if there are changes to Federal or state laws or Federal regulatory guidance or compliance information states that the drug in question is no longer approved or safe for the intended purpose.

Prior Authorization may be required for an opioid analgesic prescribed for the treatment of chronic pain, except when the drug is prescribed to you under one of the following circumstances:

1. If you are a hospice patient in a hospice care program;
2. If you are diagnosed with a terminal condition but are not a hospice patient in a hospice care program;
3. If you have cancer or another condition associated with your cancer or history of cancer.

Once a prior authorization review is approved, it will not be retroactively denied except in cases of fraudulent or materially incorrect information, or as otherwise provided under applicable state law.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells You and Your doctors about alternatives to certain prescribed Drugs. The Claims Administrator may contact You and Your doctor to make You aware of these

choices. Only You and Your doctor can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of Your Identification Card.

Covered Prescription Drug Benefits

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 Legend Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs are covered when obtained through an eligible Pharmacy. Certain contraceptives are covered under the “Preventive Services” benefit. Please see that section for further details.
- Certain supplies and equipment obtained by Home Delivery (Mail Service) or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Coinsurance. Contact the Plan to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Home Delivery (Mail Service) or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- 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.
- Flu Shots (including administration). These products will be covered under the “Preventive Services” benefit.
- Immunizations (including administration) required by the “Preventive Services” benefit.
- Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. Benefits include 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 services will be covered under the “Preventive Services” benefit. Please see that section for further details.
- 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 as designated in the FDA’s Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, and 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.
- Orally administered cancer Drugs. As required by Ohio law, you will not have to pay a cost-share (e.g., Deductible and/or Coinsurance) for the Drugs you get at a Retail or Home Delivery (Mail Order) Pharmacy that is higher than the cost-share you pay for chemotherapy covered under the “Prescription Drugs Administered by a Medical Provider” benefit.

Medication Synchronization

Medication synchronization means a pharmacy service that synchronizes the filling or refilling of prescriptions in a manner that allows the dispensed drugs to be obtained on the same date each month. Benefits are available for medication synchronization if all of the following conditions are met:

- You elect to participate in medication synchronization;

- You, the prescriber, and a Pharmacist at an Network pharmacy agree that medication synchronization is in Your best interest; * The Prescription Drug to be included in the medication synchronization meets all of the following requirements:
 1. Be covered by this Plan;
 2. Be prescribed for the treatment and management of a chronic disease or condition and be subject to refills;
 3. Satisfy all relevant prior authorization criteria;
 4. Not have quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized;
 5. Not have special handling or sourcing needs, as determined by the Plan, that require a single, designated Pharmacy to fill or refill the prescription;
 6. Be formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization;
 7. Not be a schedule II controlled substance, opiate, or benzodiazepine, as those terms are defined in Ohio law.

The Prescription Drug subject to medication synchronization must be dispensed in a quantity that is less than a 30-day supply. This requirement only applies once for each Drug subject to medication synchronization except if:

- the prescriber changes the dosage or frequency of administration or
- the prescriber prescribes a different Drug.

We must authorize coverage of a Prescription Drug subject to medication synchronization when the drug is dispensed in a quantity or amount that is less than a thirty-day supply. The Plan will apply a prorated daily cost-sharing rate for a supply of a Prescription Drug subject to medication synchronization that is dispensed at a Network Pharmacy.

Non Covered Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other Non-Covered Services)

- Prescription Drugs dispensed by any Home Delivery (Mail Service) program other than the PBM's Home Delivery (Mail Service), unless prohibited by law.
- Drugs, devices and products, or Prescription Legend 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. This Exclusion does not apply to over-the-counter products that the Plan must cover under Federal law with a Prescription.
- Off label use, except as otherwise prohibited by law or as approved by the Plan or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including, but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a diagnostic service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a Prescription by Federal law (including Drugs requiring a Prescription by state law, but not by Federal law), except for injectable insulin.
- Drugs in quantities, which exceed the limits established by the Plan, or which exceed any age limits established by the Plan.

- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Emergency contraceptives, including Plan B.
- Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, and 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.
- Treatment of Onychomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact the Plan for additional information on these Drugs.
- Prescription Drugs prescribed by a Provider that does not have the necessary qualifications and including certifications as determined by the Claims Administrator.
- 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.
- 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 "Gene Therapy Services" benefit. Please see that section for details.
- Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in Your medical records.
- 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.
- Services determined to not be Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.

Deductible/Coinsurance

Each Prescription Order may be subject to Coinsurance. If the Prescription Order includes more than one covered Drug, a separate Coinsurance will apply to each covered Drug. Your Prescription Drug Coinsurance will be the lesser of Your scheduled Coinsurance amount or the Maximum Allowed Amount. Please see the **Schedule of Benefits** for any applicable Coinsurance. If You receive Covered Services from an Out-of-Network Pharmacy, a Coinsurance amount may also apply.

Days Supply

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 the Plan may let You get an early refill. For example, the Plan may let You refill Your prescription early if it is decided that You need a larger dose. The Claims Administrator 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 the 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.

Formulary

The Plan follows a drug Formulary in determining payment and Covered Services. You will be responsible for an additional Coinsurance amount depending on whether a Formulary or non-Formulary drug is obtained. Please see the **Schedule of Benefits**.

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance 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 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 have a higher Coinsurance 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. The Plan decides coverage for doses and administration (i.e., oral, injection, topical, or inhaled). The Plan may cover one form of administration instead of another, or put other forms of administration in a different tier.

Special Programs

Except when prohibited by Federal regulations (such as HSA rules), from time to time the Claims Administrator or the PBM may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, Home Delivery (Mail Service) Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Coinsurance for certain Drugs or preferred products for a limited period of time.

Rebate Impact on Prescription 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 Allowable 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.

Payment of Benefits

The amount of benefits paid is based upon whether You receive the Covered Services from a Network Pharmacy, an Out-of-Network Pharmacy, or the PBM's Home Delivery (Mail Service) Program. It is also based upon which Tier the Claims Administrator has classified the Prescription Drug. Please see the **Schedule of Benefits** for the applicable amounts, and for applicable limitations on number of days supply.

The Claims Administrator retains the right at the Claims Administrator's discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which You are responsible are shown in the **Schedule of Benefits**. No payment will be made by the Plan for any Covered Service unless the negotiated rate exceeds any applicable Coinsurance for which You are responsible.

Your Coinsurance amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors. For Covered Services provided by a Network Pharmacy or through the PBM's Home Delivery (Mail Service), You are responsible for all Coinsurance amounts.

For Covered Services provided by an Out-of-Network Pharmacy, You will be responsible for the amount(s) shown in the **Schedule of Benefits**. This is based on the Maximum Allowed Amount.

How to Obtain Prescription Drug Benefits

How You obtain Your benefits depends upon whether You go to a Network or an Out-of-Network Pharmacy.

Network Pharmacy

Present Your written Prescription order from Your Physician and Your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file Your claim for You. You will be charged at the point of purchase for applicable Coinsurance amounts. If You do not present Your Identification Card, You will have

to pay the full retail price of the Prescription. If You do pay the full charge, ask Your pharmacist for an itemized receipt and submit it to the Plan with a written request for refund.

Out-of-Network Pharmacy

You are responsible for payment of the entire amount charged by the Out-of-Network Pharmacy , including an Out-of-Network Specialty Pharmacy. You must submit a Prescription Drug claim form to the Plan for reimbursement consideration. These forms are available from the Claims Administrator or from the Employer. You must complete the top section of the form and ask the Out-of-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, You must attach an itemized receipt to the claim form and submit to the Plan or the PBM.

The itemized 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 Drug;
- cost of the Prescription; and,
- quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the **Schedule of Benefits**. This is based on the Maximum Allowed Amount as determined by Anthem or the PBM's normal or average contracted rate with network pharmacies on or near the date of service.

The Home Delivery (Mail Service) Program

Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written Prescriptions from Your Physician, or have Your Physician fax the Prescription to the PBM's Home Delivery (Mail Service). Your Physician may also phone in the Prescription to the PBM's Home Delivery (Mail Service) Pharmacy. You will need to submit the applicable Coinsurance and/or Coinsurance amounts to the PBM's Home Delivery (Mail Service) when You request a Prescription or refill.

LIMITATIONS AND EXCLUSIONS

These limitations and exclusions apply even if a qualified practitioner has performed or prescribed a Medically Necessary procedure, treatment or supply. This does not prevent Your qualified practitioner from providing or performing the procedure, treatment or supply. Regardless, the procedure, treatment or supply will not be a covered expense.

1. Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military Facilities except as required by law.
2. Services for Custodial Care.
3. Services for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.
4. Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
5. Charges for treatment received before coverage under this option began or after it is terminated.
6. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Member is being treated.
7. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis or treatment of an illness or injury, as determined by the Claims Administrator.
8. Foot care only to improve comfort or appearance, routine care of corns, calluses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
9. Shoe inserts, orthotics (will be covered if prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary).
10. Treatment where payment is made by any local, state, or Federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
11. 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 listed in this Benefit Booklet or as required by Federal law, as described in the section titled "Medicare" in **General Information**. If You do not enroll in Medicare Part B when You are eligible, You may have large Out-of-Pocket costs. Please refer to Medicare.gov for more details on when You should enroll and when You are allowed to delay enrollment without penalties.
12. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by similar statutory programs.
13. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.
14. Outpatient prescription drugs prescribed by a Physician and purchased or obtained from a retail pharmacy or retail pharmacist or a mail service pharmacy are excluded. These may be covered by a separate drug card program but not under this medical plan. Although coverage for outpatient Prescription Drugs obtained from a retail pharmacy or pharmacist or mail service Pharmacy is excluded, certain Prescription Drugs are covered under Your medical benefits when rendered in a Hospital, in a Physician's office, or as part of a Home Health Care benefit.

Therefore, this exclusion does not apply to prescription drugs provided as Ancillary Services during an Inpatient stay or an Outpatient Surgical procedure; to prescription drugs used in conjunction with a Diagnostic Service; Chemotherapy performed in the office; home infusion or home IV therapy, nor drugs administered in Your Physician's office.

15. Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
16. Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
17. Vitamins, minerals and food supplements, as well as vitamin injections not determined to be Medically Necessary in the treatment of a specific illness. Nutritional supplements, services, supplies and/or nutritional sustenance products (food) related to enteral feeding, except when determined to be Medically Necessary.
18. Services for Hospital confinement primarily for diagnostic studies.
19. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, except for reconstructive surgery following a mastectomy or when Medically Necessary to correct damage caused by an accident, an injury or to correct a congenital defect.
20. Donor Search/Compatibility, except as otherwise indicated.
21. Hearing aids, hearing devices or examinations for prescribing or fitting them.
22. Contraceptive Drugs, except for any above stated covered contraceptive devices.
23. In-vitro Fertilization, Artificial Insemination and as indicated on the Plan Design.
24. Hair transplants, hairpieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
25. Services and supplies primarily for educational, vocational or training purposes, including but not limited to structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in this Benefit Booklet.
26. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
27. Christian Science practitioner services.
28. Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law.
29. Services provided in a halfway house.
30. Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Member by a local, state or Federal government agency, or by a public school system or school district, except when the plan's benefits must be provided by law; services if the Member is not required to pay for them or they are provided to the Member for free.
31. Services or supplies provided by a member of Your family or household.
32. Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator.
33. Fees or charges made by an individual, agency or Facility operating beyond the scope of its license.
34. Services and supplies for which You have no legal obligation to pay, or for which no charge has been made or would be made if You had no health insurance coverage.

35. Charges for any of the following:
 - a. Failure to keep a scheduled visit;
 - b. Completion of claim forms or medical records or reports unless otherwise required by law;
 - c. For Physician or Hospital's stand-by services;
 - d. For holiday or overtime rates.
 - e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
 - f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
36. Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered Facility, which makes their services available.
37. Personal comfort items such as those that are furnished primarily for Your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications. Supplies, equipment and appliances 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 Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is Your responsibility.
38. Reversal of vasectomy or reversal of tubal ligation.
39. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes and/or which are performed as a treatment for acne.
40. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.
41. Vision care services and supplies, including but not limited to eyeglasses, contact lenses and related or routine examinations and services. Eye refractions. Analysis of vision or the testing of its acuity. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery or for soft contact lenses due to a medical condition, i.e. diabetes.
42. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
43. Services for weight loss programs, services and supplies. Weight loss programs include, but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss).
44. For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than: as a therapeutic abortion (abortion recommended by a Provider) performed to save the life or health of the mother, or as a result of incest or rape; or miscarriage due to a spontaneous abortion (occurs naturally and suddenly).
45. For care received in an emergency room which is not Emergency Care, except as specified in this Benefit Booklet. This includes, but is not limited to suture removal, routine pregnancy test, sore throat, ear ache/infection, rashes, sprains/strains, constipation, diarrhea, upper respiratory illness, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, dental caries/cavity. For non-Emergency Care please use the closest Network Urgent Care Center and/or your Primary Care Physician for services.
46. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

CLAIMS PAYMENT

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if the BlueCard® PPO Network Hospitals, Physicians and ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the Provider requests a claim form to file a claim, a claim form can be obtained by contacting Your local Human Resources Department or by visiting www.anthem.com.

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign Providers from sending Your claims and other personal information to the Claims Administrator.

How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within **12** months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan.

When You receive Covered Services from a Network Physician or other Network licensed health care Provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the Provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from Your Employer or the Claims Administrator. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Maximum Allowed Amount

General

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

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

- that meet the Plan's 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 Coinsurance. In addition, when You receive Covered Services from an Out-of-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

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 Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's 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 and/or reimbursement policies. 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 Physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts 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 a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because 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 Coinsurance. Please call Member Services for help in finding a 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 Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established at 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 Administrator will update such information, which is 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.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator’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 Plan would use if the healthcare services had been obtained within the Claims Administrator’s Service Area, or a special negotiated price.

Unlike Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider’s charge that exceeds the Plan’s Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket costs to You. Please call Member Services for help in finding a Network Provider or visit the Claims Administrator’s website at www.anthem.com.

Member Services is also available to assist You in determining this Plan’s Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider 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 (PBM).

Member Cost Share

For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a 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 Providers. Please see the **Schedule of Benefits** 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 a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Benefit Booklet and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or Facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain Prescription Drug purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to Your Deductible, if any, or taken into account in determining Your Coinsurance.

Authorized Services

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible 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. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes a 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. Please contact Member Services for Authorized Services information or to request authorization.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. If services are performed by Out-of-Network Providers, then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount with or without a referral or regardless if allowed as an Authorized Service. Contact the Claims Administrator for more information.

Processing Your Claim

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

Timeliness of Filing for Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within **12** months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Necessary Information

In order to process Your claim, the Claims Administrator may need information from the Provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other Provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

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.

Member's Cooperation

You will be expected to complete and submit to us 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 (including if You fail to enroll under Part B of the Medicare program where Medicare is the responsible payer), You will be responsible for any charge for services.

Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;
- the amount for which You are responsible (if any); and
- general information about Your appeals rights and for ERISA plans, information regarding the right to bring an action after the appeals process.

Inter-Plan Arrangements

Out-of-Area Services

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 its 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. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process Your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. 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.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Employer on Your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. 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.

E. Nonparticipating Providers Outside the Claims Administrator's Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's 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 and/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 the Plan 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 make for the Covered Services as set forth in this paragraph.

F. 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. Remember to take an up to date health Identification Card with You.

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 the Claims Administrator 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 **Health Care Management – Precertification** 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 Core® claim forms You can get international claims forms in the following ways:

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

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

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. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Assignment

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 Service. 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 Employer'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.

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, if subject to ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

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

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

Questions About Coverage or Claims

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Member Services Department. Be sure to always give Your Member identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- Provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call the Claims Administrator.

The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor the Claims Administrator is responsible for any Injuries or damages You may suffer due to actions of any Hospital, Physician or other person. In order to process Your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of Your benefits by an employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of Your new address.

YOUR RIGHT TO APPEAL

The Claims Administrator's Member Services representatives are trained to answer your questions about your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Coinsurance amounts,
- Specific claims or services you have received,
- Doctors or Hospitals in the Network,
- Referral processes or authorizations,
- Provider directories.

Complaint and Appeal procedures have been established to provide fair, reasonable, and timely solutions to complaints that you may have concerning the Plan. The Plan invites you to share any concerns that you may have over benefit determinations, coverage and eligibility issues, or the quality of care rendered by medical Providers in the Claims Administrator's Networks.

The Complaint Procedure

The Plan wants your experience 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. The Claims Administrator will try to resolve your complaint informally by talking to your Provider or reviewing your claim. Please refer to your Identification Card for the Claims Administrator's address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Claims Administrator of its' procedures and your benefit document. You may submit your complaint by letter or by telephone call. If your complaint involves issues of Covered Services, you may be asked to sign a release of information form so the Claims Administrator can request records for its' review.

You will be notified of the resolution of your complaint if a claim or request for benefits is denied in whole or in part. The Claims Administrator will explain why benefits were denied and describe your rights under the Appeal Procedure. If you are not satisfied with the resolution of your complaint, you have the right to file an Appeal, which is defined as follows:

Appeal Procedures

As a Member of this Plan you have the right to appeal decisions to deny or limit your health care benefits. The explanation of why the Plan denied your claim or request for benefits will describe the steps you should follow to initiate your appeal and how the appeal process works.

An appeal is a request from you for the Claims Administrator to change a previous determination or to address a concern you have regarding confidentiality or privacy.

Internal Appeals

An initial determination by the Claims Administrator can be appealed for internal review. The Plan will advise you of your rights to appeal to the next level if a denial occurs after an initial determination.

You have the right to designate a representative (e.g. your Physician) to file appeals with the Claims Administrator on your behalf and to represent you in any level of the appeals process. If a representative is seeking an appeal on your behalf, the Claims Administrator must obtain a signed Designation of Representation (DOR) form from you. The appeal process will not begin until the Claims Administrator has received the properly completed DOR form except that if a Physician requests expedited review of an appeal on your behalf, the Physician will be deemed to be your designee for the limited purpose of filing for expedited review of the appeal without receipt of a signed form. The Claims Administrator will forward a Designation of Representation form to you for completion in all other situations.

The Claims Administrator will accept oral or written comments, documents or other information relating to an appeal from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal. If, after the Claims Administrator's determination that you are appealing, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with your claim, the Claims Administrator will provide you with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal(s) decision(s) on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the appeal procedures outlined under this section the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

To obtain information on the Claims Administrator's appeal procedures or to file an oral appeal please call the toll free Member Services number listed on the back of your Plan Identification Card or the number provided for appeals on any written notice of an adverse decision that you receive from the Claims Administrator.

The Claims Administrator will also accept appeals filed in writing. If you wish to file your appeal in writing, you must mail it to: Anthem Blue Cross and Blue Shield, P.O. Box 105568, Atlanta, GA 30348, or to the address provided for filing an appeal on any written notice of an adverse decision that you receive from the Claims Administrator.

Appeals are reviewed by persons who did not make the initial determination and who are not the subordinates of the initial reviewer. If a clinical issue is involved, the Claims Administrator will use a clinical peer for this review. A clinical peer is a Physician or Provider who has the same license as the Provider who will perform or has performed the service. The clinical peer will review your medical records and determine if the service is covered by your benefit document. If the clinical peer determines that the service is covered by your benefit document the Plan must pay for the service; if the clinical peer determines that the service is not covered the Plan may deny the services.

Standard Appeals

If you are appealing an adverse precertification decision other than a retrospective post-claim review decision (i.e., an adverse prospective, concurrent or retrospective pre-claim review decision) or the denial of any prior approval required by the Plan, the Claims Administrator will provide you with a written response indicating the Claims Administrator's decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days of the date the Claims Administrator receives your appeal request. If more information is needed to make a decision on your Appeal, the Claims Administrator will send a written request for the information after receipt of the Appeal. No extensions of time for additional information may be taken on these Appeals without the permission of the Member. Therefore, the Claims Administrator will make a decision based upon the available information if the additional information requested is not received.

If you are appealing any other type of adverse decision (including retrospective post-claim review decisions) and sufficient information is available to decide the Appeal, the Claims Administrator will provide you with a written response indicating its' decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days from receipt of the Appeal request. If more information is needed to make a decision on your Appeal, the Claims Administrator shall send a written request for the information after receipt of the Appeal. If the additional information requested is not received within 45 calendar days of the Appeal request, the Claims Administrator shall conduct its review based upon the available information.

Appeal of an Adverse Pre-service Review/Prior Authorization Decision

If the Plan's decision regarding your Pre-service Review or Prior Authorization of a health care service, device, or drug submitted electronically by your Provider is appealed, the Plan will consider the appeal:

- Within forty-eight (48) hours after the appeal is received if it's for Urgent Care Services;
- Within ten (10) calendar days after the appeal is received for all other services if it's for non-Emergency or non-Urgent Care Services.

The appeal shall be between the Provider requesting the service in question and a clinical peer.

If the appeal does not resolve the disagreement, either you or your authorized representative may request an External Review as described in this section.

For purposes of this section only, Urgent Care Services means medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
- In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of a Pre service Review request as outlined in the Health Care Management section of this Benefit Booklet.

This section does not apply to Emergency services.

Once a Pre-service Review or Prior Authorization is approved, it will not be retroactively denied except in cases of fraudulent or materially incorrect information, or as otherwise provided under applicable state law.

Expedited Appeals

An expedited appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Given the urgent nature of an expedited appeal, you are encouraged to request an expedited appeal orally. An expedited appeal is available only if the medical care for which coverage is being denied has not yet been rendered. The Claims Administrator will complete expedited review of an appeal as soon as possible given the medical exigencies but no later than seventy-two hours (72 hours) after the Claims Administrator's receipt of the request and will communicate the Claims Administrator's decision by telephone to your attending Physician or the ordering Provider. The Claims Administrator will also provide written notice of the Claims Administrator's determination to you, your attending Physician or ordering Provider, and the Facility rendering the service.

You may request an expedited review for:

Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

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

Except as provided above, a claim involving urgent care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Any claim that a Physician with knowledge of your medical condition determines is a claim involving urgent care.

Exhaustion of Internal Appeals Process

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

- The Claims Administrator agrees to waive the exhaustion requirement; or
- You did not receive a written decision of the Claims Administrator's internal appeal within the required time frame; or
- The Claims Administrator failed to meet all requirements of the internal appeal process unless the failure:
 1. Was de minimis (minor);
 2. Does not cause or is not likely to cause prejudice or harm to you;
 3. Was for good cause and beyond the Claims Administrator's control;
 4. Is not reflective of a pattern or practice of non-compliance; or
- An expedited external review is sought simultaneously with an expedited internal review.

External Review

Definitions as used in the External Review section include the following:

“Adverse benefit determination” means a decision by a health plan issuer:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
 - A determination that the health care service does not meet the health plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
 - A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non employer group, to participate in a plan or health insurance coverage;
 - A determination that a health care service is not a covered benefit;
 - The imposition of an exclusion, including exclusions source of injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To rescind coverage on a health benefit plan.

“Authorized representative” means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family member or a treating health care professional, but only when the covered person is unable to provide consent.

“Covered person” means a subscriber, enrollee, member, or individual covered by a health benefit plan. “Covered person” does include the covered person's authorized representative with regard to an internal appeal or external review.

“Covered benefits” or **“benefits”** means those health care services to which a covered person is entitled under the terms of a health benefit plan.

“Final adverse benefit determination” means an adverse benefit determination that is upheld at the completion of a health plan issuer’s internal appeals process.

“Health benefit plan” means a benefit plan offered by an Employer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

“Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

“Health plan issuer” means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. “Health plan issuer” includes a third party Claims Administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent. The “Health plan issuer” is also called the Claims Administrator in this Benefit Booklet.

“Independent review organization” means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.

“Rescission” or **“to rescind”** means a cancellation or discontinuance of coverage that has a retroactive effect. “Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

“Stabilize” means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
 - Serious impairment to bodily functions;
 - Serious dysfunction of any bodily organ or part.
- In the case of a woman having contractions, “stabilize” means such medical treatment as may be necessary to deliver, including the placenta.

“Superintendent” means the superintendent of insurance.

Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. This is a summary of that external review process. An adverse benefit determination is a decision by the Plan to deny benefits because services are not covered, are excluded, or limited under the plan, or the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review.

However, the covered person must generally exhaust the health plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

External Review by an IRO - A covered person is entitled to an external review by an IRO in the following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information.
- The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person's health benefit plan, and the treating physician certifies at least one of the following:
 - Standard health care services have not been effective in improving the condition of the covered person.
 - Standard health care services are not medically appropriate for the covered person.
 - No available standard health care service covered by the Plan is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.
- The covered person's treating physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a Facility.
- An expedited internal appeal is already in progress for an adverse benefit determination of experimental or investigational treatment and the covered person's treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

Note: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person).

External Review by the Ohio Department of Insurance - A covered person is entitled to an external review by the Department in the either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The adverse benefit determination for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND the Claims Administrator's decision has already been upheld through an external review by an IRO.

Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through the Claims Administrator within 180 days of the date of the notice of final adverse benefit determination issued by the Claims Administrator. All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally; however written confirmation of the request must be submitted to the Claims Administrator no later than five (5) days after the initial request. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete the Claims Administrator will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. The Claims Administrator will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete the Claims Administrator will inform the covered person in writing and specify what information is needed to make the request complete. If the Claims Administrator determines that the adverse benefit determination is not eligible for external review, the Claims Administrator must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by the Claims Administrator and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment

When the Claims Administrator initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with the Claims Administrator, the covered person, the health care provider or the health care Facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by the Claims Administrator in making the adverse benefit determination, any information submitted by the covered person and other information such as; the covered person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by the Claims Administrator of a request for a standard review or within 72 hours of receipt by the Claims Administrator of a request for an expedited review. This notice will be sent to the covered person, the Claims Administrator and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.

- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

Note: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An external review decision is binding on the Plan except to the extent the Claims Administrator has other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law. A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to the Claims Administrator.

If You Have Questions About Your Rights or Need Assistance

You may contact the Claims Administrator:

Anthem Blue Cross and Blue Shield
P.O. Box 105568, Atlanta, GA 30348

To contact the Claims Administrator by phone please call the number on back of your identification card

Fax: **1-888-859-3046**

E-Mail: Ohio.Appeals@anthem.com

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>

Appeal Filing Time Limit

The Plan expects that you will use good faith to file an appeal on a timely basis. However, the Claims Administrator will not review an appeal if it is received after 180 days have passed since the incident leading to your appeal.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill You for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than the Plan's Maximum Allowed Amount.

COB Definitions

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non-group insurance contracts and subscriber contracts; Health Maintenance Organization (HMO) contracts; uninsured arrangements of group or group-type coverage; coverage under group or non-group closed panel plans; group-type contracts; medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); other governmental benefits, except for Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.
2. Plan does not include: Accident only coverage; specified disease or specified accident coverage; limited health benefit coverage; benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; school accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non-Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount that is subject to the Primary high-Deductible health plan's Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-Deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
6. Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

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

Order of Benefit Determination Rules

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an Employee, Member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an Employee, Member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
 - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - the Plan covering the custodial parent;
 - the Plan covering the Spouse of the custodial parent;
 - the Plan covering the non-custodial parent; and then
 - the Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of items 1 or 2 above will determine the order of benefits as if those individuals were the parents of the child.

4. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouses plan, Rule 5 applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule in item 1 above to the Dependent child's parent(s) and the Dependent's spouse.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active Employee, that is, an Employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off Employee is the Secondary Plan. The same would hold true if You are a Dependent of an active Employee and You are a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other Federal law and are covered under another Plan, the Plan covering You as an Employee, Member, subscriber or retiree or covering You as a Dependent of an Employee, Member, subscriber or retiree is the Primary Plan and the COBRA or other Federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an Employee or as a retired Employee and is covered under his or her own Plan as an Employee, Member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a Dependent of an Employee, Member or subscriber or retired Employee and is covered under the other plan as a Dependent of an Employee, Member, subscriber or retiree).

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule 6 - If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of this Plan

When a Member is covered under two or more Plans which together pay more than the Allowable expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is primary. However, when this Plan is secondary under the Order of Benefit Determination Rules, it starts with this Plan's Allowable expense, deduct the Primary Plan's payment and then deduct any Deductibles and/or Coinsurance.

If You are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming 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 give the Claims Administrator any facts the Claims Administrator needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Subscribers with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don't accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if You had been enrolled in Medicare.

SUBROGATION AND REIMBURSEMENT

These 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.

Recovery

A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, workers' compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- 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.
- 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.

Reimbursement

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 and the following provisions will apply:

- 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.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the 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.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.

- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. 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.
- 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 that 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.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

Your Duties

- 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 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 must not do anything to prejudice the Plan's rights.
- 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.

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

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 this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

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.

GENERAL INFORMATION

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or attachments, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between the Claims Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Claims Administrator by the Employer, and any and all statements made to the Employer by the Claims Administrator, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

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.

Circumstances beyond the Control of the Plan

The Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of Facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical, the Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

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 Your Identification Card.

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent Employer liability or indemnification law.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payer, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

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 required us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part 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 Part B when You are eligible, You may have large out-of-pocket costs. Please refer to [Medicare.gov](https://www.medicare.gov) for more details on when You should enroll, and when You are allowed to delay enrollment without penalties.

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.

The Claims Administrator has oversight responsibility for compliance with Provider and vendor contracts. The Claims Administrator 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, the Claims Administrator has 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. The Claims Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

Relationship of Parties (Employer-Member-Claims Administrator)

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

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

Relationship of Parties (Claims Administrator - Network Providers)

The relationship between the Claims Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Claims Administrator, nor is the Claims Administrator, or any employee of the Claims Administrator, an employee or agent of Network Providers.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including 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 the Claims Administrator.

Note

The Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer and Anthem and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Ohio. The Blue Cross and 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, Anthem is 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. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business and/or to You at the Subscriber's address as it appears on the records or in care of the Employer.

Modifications or Changes in Coverage

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.

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Acts beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable state and Federal law. It is the Plan Sponsor's responsibility to adhere to all applicable state and Federal laws and the Claims Administrator does not assume any responsibility for compliance.

Conformity with Law

Any provision of the Plan which is in conflict with the applicable Federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

Policies and Procedures

The Claims Administrator, on behalf of the Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Member shall comply.

Under the terms of the Administrative Service Agreement with Your Employer, the Claims Administrator has the authority, at its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's 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. The Claims Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to the Employer.

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 the Plan but are in addition to plan benefits. As such, program features are not guaranteed under Your Employer's Group health Plan 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.

Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the 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.

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 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.

Reservation of Discretionary Authority

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its 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 all 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. Anthem has complete discretion to interpret the Benefit Booklet. The Claims Administrator's determination shall be final and conclusive and 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.

Governmental Health Care Programs

Under Federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

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 Physicians from various medical specialties including the Claims Administrator's medical directors, Physicians in academic medicine and Physicians 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.

Payment Innovation Programs

The Claims Administrator pays 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 the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to the Claims Administrator 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 Network Provider's achievement of these pre-defined standards. You are not responsible for any Coinsurance amounts related to payments made by or to the Claims Administrator under the Program(s), and You do not share in any payments made by Network Providers to the Claims Administrator under the Program(s).

Care Coordination

The Plan pays Network Providers in various ways to provide Covered Services to You. For example, sometimes the Plan may pay Network Providers a separate amount for each Covered Service they provide. The Plan may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Plan may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Plan may pay 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 Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the Plan because they did not meet certain standards. You do not share in any payments made by Network Providers to the Plan under these programs.

Program Incentives

The Plan may offer incentives from time to time, at its discretion, in order to introduce You to covered programs and services available under this Plan. The purpose of these incentives include, but is 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 the Plan offers the incentives program. The Plan may discontinue 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, it is recommended that You consult Your tax advisor.

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 our policies and procedures regarding the protection, use and disclosure of Your medical information is available on our website and can be furnished to You upon request by contacting our 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 Benefit Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

WHEN COVERAGE TERMINATES

Termination of Coverage (Individual)

Membership for You and Your enrolled family members may be continued as long as You are employed by the Employer and meet eligibility requirements. It ceases if Your employment ends, if You no longer meet eligibility requirements, if the Plan ceases, or if You fail to make any required contribution toward the cost of Your coverage. In any case, Your coverage would end at the expiration of the period covered by Your last contribution.

Coverage of an enrolled child ceases at the end of the month when the child attains the age limit shown in the **Eligibility** section. Coverage of an impaired child over age 26 ceases if the child is found to be no longer totally or permanently impaired.

Continuation of Coverage (Federal Law-COBRA)

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with Federal law. If Your Employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer if You have any questions about Your COBRA rights.

Qualifying Events for Continuation Coverage Under Federal Law (COBRA)

COBRA continuation coverage is available when Your group 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 covered on the day before the qualifying event and group 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 company’s Employee welfare benefit 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
<p><u>For Employees:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer’s Health Plan Due to Reduction In Hours Worked</p>	18 months
<p><u>For Spouses/ Dependents:</u> A Covered Employee’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</p>	18 months
Covered Employee’s Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Employee	36 months

Qualifying Event	Length of Availability of Coverage
<u>For Dependents:</u> Loss of Dependent Child Status	36 months

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then 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.)

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 Spouse and Dependent children 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 Spouse or Dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company’s benefit Plan Administrator within 30 days. You must notify the company’s benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled Dependents to meet the program’s definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

To continue enrollment, 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 premium appropriate for the type of benefit coverage You choose to continue. If the premium rate changes for active associates, Your monthly premium will also change. The premium You must pay cannot be more than 102% of the premium 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 premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

For Employees 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 Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees’ Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of premium 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

These 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 premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA;
- a covered individual becomes entitled to Medicare after electing COBRA; or
- the group 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 Group's health Plan and Your COBRA continuation coverage rights should be addressed to the Employer. For more information about Your rights under ERISA, if this Plan is subject to 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 During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the Plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the premiums and the Employee is only required to pay his or her share of the premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he

or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

Continuation of Coverage Due to Family and Medical Leave (FMLA)

An Employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An Employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- the birth of the Employee's child;
- the placement of a child with the Employee for the purpose of adoption or foster care;
- to care for a seriously ill Spouse, child or parent; or,
- a serious health condition rendering the Employee unable to perform his or her job.

If the Employee chooses to continue coverage during the leave, the Employee will be given the same health care benefits that would have been provided if the Employee were working, with the same premium contribution ratio. If the Employee's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the Employee. It will tell the Employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If membership in the Plan is discontinued for non-payment of premium, the Employee's coverage will be restored to the same level of benefits as those the Employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible Dependents. The Employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.

For more information about Your rights under ERISA, if this Plan is subject to ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact 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.

DEFINITIONS

Accidental Injury

Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

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. This Benefit Booklet in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Administrative Services Agreement, the Administrative Services Agreement shall control.

Ambulance Services

A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Authorized Service(s)

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member may be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Network Coinsurance and/or Deductible. For more information, see the **Claims Payment** section.

Behavioral Health Care

Includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is 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.

Benefit Period

One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

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 Drugs

The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical name (Generic).

Centers of Excellence (COE) Network

A network of health care Facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Anthem Insurance Companies, Inc. 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).

Combined Limit

The maximum total of Network and Out-of-Network benefits available for designated health services in the **Schedule of Benefits**.

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, Physician-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.

Congenital Anomaly

A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Controlled Substances

Drugs and other substances that are considered Controlled Substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Coordination of Benefits

A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Cosmetic Surgery

Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to: rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent

Any Dependent in a Subscriber's family who meets all the requirements of the **Eligibility** section of this Benefit Booklet, has enrolled in the Plan, and is subject to administrative service fee requirements set forth by the Plan.

Covered Services

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible

The portion of the bill You must pay before Your medical expenses become Covered Services.

Dependent

The Spouse and all children until attaining age limit stated in the **Eligibility** section. Children include natural children, legally adopted children, foster children that live with the Employee and for whom the Employee is the primary source of financial support, and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Mentally, intellectually or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a Facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

Durable Medical Equipment

Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date

The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Emergency (Emergency Medical Condition)

An accidental traumatic bodily injury or other medical or behavioral health condition that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- Place the health of an individual, or the health of another person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care (Emergency Services)

A medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and Facilities available at the Hospital, such further medical or behavioral health examinations and treatment as are required to Stabilize the patient.

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.

Experimental/Investigative

Any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

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

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

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

- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or Facilities or by other treating Physicians, other medical professionals or Facilities studying substantially the same Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Facility

A Facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined in this Benefit Booklet. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

Formulary

A document setting forth certain rules relating to the coverage of pharmaceuticals, that may include but not be limited to (1) a listing of preferred Prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator, and are dispensed to Members through pharmacies that are Network Providers, and (2) Precertification rules. This list is subject to periodic review and modification. Charges for medications may be Ineligible Charges, in whole or in part, if a Member selects a medication not included in the Formulary.

Freestanding Ambulatory Facility

A Facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis (no patients stay overnight). The Facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed and accredited by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Generic Drugs

Drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicates those of a Brand Name Drug and is its bioequivalent, Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

Group Health Plan or Plan

An employee welfare benefit plan (as defined in Section 3(1) of ERISA) established by the Employer, in effect as of the Effective Date.

Home Delivery (Mail Service)

A Prescription Drug program which offers a convenient means of obtaining maintenance medications by mail if the Member takes Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Home Delivery (Mail Service), which has entered into a reimbursement agreement with the Claims Administrator and sent directly to the Member's home.

Home Health Care

Care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency

A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

Hospice

A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed and accredited by the appropriate agency.

Hospice Care Program

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed and accredited by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital

An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic Facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care Facility; nursing home; place for rest; Facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

Identification Card

The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

Ineligible Charges

Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

Ineligible Provider

A Provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a Provider are not eligible for payment.

Infertile or Infertility

The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee

A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

Injury

Bodily harm from a non-occupational accident.

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 Care Unit

A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Intensive In-Home Behavioral Health Programs

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 Programs

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

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, is expected to produce the same clinical result as the reference product in any given patient.

Late Enrollees

Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan; (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

Maternity Care

Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

Maximum Allowed Amount

The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the **Claims Payment** section.

Medical Necessity (Medically Necessary)

Procedures, supplies, equipment, or services that we conclude are:

1. Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
2. Given for the diagnosis or direct care and treatment of the medical condition; and
3. Within the standards of good medical practice within the organized medical community; and
4. Not mainly for the convenience of the Doctor or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely given.

The most appropriate procedure, supply, equipment, or service must meet the following requirements:

1. There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and will have a greater chance of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and
2. Generally approved forms of treatment that are less invasive have been tried and did not work or are otherwise unsuitable; and
3. For Hospital stays, acute care as an Inpatient is needed due to the kind of services the patient needs or the severity of the medical condition, and that safe and adequate care cannot be given as an outpatient or in a less intensive medical setting.

The most appropriate procedure, supply, equipment, or service must also be cost-effective compared to other alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of Your illness, Injury or disease, the service is: (1) not more costly than another service or group of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

Member

Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

Network Provider

A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or Facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements. A Network Provider for one plan may not be a Network Provider 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 a Network Provider for this Plan.

New Hire

A person who is not employed by the Employer on the original Effective Date of the Plan.

Non-Covered Services

Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Out-of-Network Provider

A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

Out-of-Pocket Maximum

The maximum amount of a Member's Coinsurance payments during a given calendar Plan year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery (Mail Service) 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. Anthem's PBM, in consultation with Anthem, also provide 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.

Physical Therapy

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

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.**

Prescription Drug (Drug) (Also referred to as Legend Drug)

A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin.

Prescription Order or Prescription

A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician

A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization

The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider

A duly licensed person or Facility that provides services within the scope of an applicable license and is a person or Facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question if a Provider is covered, please call the number on the back of Your Identification Card.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Employee is entitled under the Plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided and each plan to which the order applies.

An MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a Group Health Plan Member or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a Group Health Plan.

Residential Treatment Center/Facility

A Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured Facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

A Facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Semiprivate Room

A Hospital room which contains two or more beds.

Skilled Convalescent Care

Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient’s home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility

An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

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

Typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require preauthorization to be considered Medically Necessary.

Spouse

For the purpose of this Plan, a Spouse is defined as shown in the **Eligibility** section of this Benefit Booklet.

Therapeutic Equivalent

Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

Transplant Providers

Network Transplant Provider - A Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

Urgent Care

Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, procedures, and/or Facilities.

You and Your

Refer to the Subscriber, Member and each Covered Dependent.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

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 the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's 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, or procedures for making referrals. 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 the Claims Administrator's website, www.anthem.com.

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 (e.g., Your Physician, nurse midwife, or Physician assistant), 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). However, to use certain Providers or Facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

Also, under Federal law, plans may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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**.

If You would like more information on WHCRA benefits, call Your Plan Administrator.

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 Your Employer or Plan Administrator 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 abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Coinsurance and Out-of-Pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Coinsurance and Out-of-Pocket expenses applicable to other medical and surgical benefits. 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 You or Your Dependents' other coverage). However, You must request enrollment within 31 days after You 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 31 days after the marriage, birth, adoption, or placement for adoption.

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

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

The Employee 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 the Member Services telephone number on Your Identification Card or contact Your Plan Administrator.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Company (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

IT'S IMPORTANT WE TREAT YOU FAIRLY

That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. 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 Identification Card for help (TTY/TDD: 711). If You think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, You can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or You can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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 Identification 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 Member Services telephone number on the back of Your Identification 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)

Albanian

Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic

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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)

Bassa

Ɖ bédé dyí-bèdèìn-dèè bɛ̀ m̀ ké bʒ̀ nìà kɛ̀ kè gbo-kpá- kpá dyé dé̀ m̀ bídí-wùdùùn b́ó pídyi. Ɖá mébà jè gbo-gm̀ Kpòè nòbà nìà nì Dyí-dyoìn-bèṣ kṣɛ̀ bɛ̀ m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali

আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese

ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။

(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)

Dinka

Yin non yic ba ye lek ne yok ku be yi kuony ne thon yin jam ke cin weu tou ke piiny. Col ran ton de koc ke luoi ne namba den to ne I.D kat du yic. (TTY/TDD: 711)

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstnummer op uw ID-kaart voor ondersteuning. (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)

German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (Identification card) για βοήθεια. (TTY/TDD: 711)

Gujarati

તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (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)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo

! nwere ikike inweta ozi a yana enyemaka n'asusu gi n'efu. Kpoo nomba Oru Onye Otu di na kaadi NJ gi maka enyemaka. (TTY/TDD: 711)

Ilokano

Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian

Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (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)

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)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលបានព័ត៌មាននេះ និងទទួលបានជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលបានជំនួយ។ (TTY/TDD: 711)

Kirundi

Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (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)

Lao

ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທຂອງພວກເຮົາ ຫຼື ການສະມາຊິກທ່ານໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo

Bee ná ahoot'i' t'áá ni nizaad k'ehjíníká á a'doowol t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áají' hodíílnih. (TTY/TDD: 711)

Nepali

तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo

Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch

Du hoscht die Recht selle Information un Hilfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Hilfe aa. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian

Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apălați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (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)

Samoan

E iai lou 'aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian

Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (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 Identification card para sa tulong. (TTY/TDD: 711)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian

Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu

آپ کو اپنی زبان میں مفت ان معلومات اور مدد کے حصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711)۔

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish

רופט די איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
(TTY/TDD:711) פאר הילף און אייער קארטל פאר הילף

Yoruba

O ní ètò láti gba ìwífún yí kí o sì sèrànwọ ní èdè rẹ lófẹ́ẹ́. Pe Nọmbà àwọn ìpèsè ọmọ-ẹgbé lórí kààdì ìdánimọ rẹ fún ìrànwọ. (TTY/TDD: 711)