Indiana State
Personnel Department

MEDICAL BENEFIT BOOKLET

For

STATE OF INDIANA
CDHP 2
Effective 1-1-2027

Administered By

Anthem

Invest In Your Health

Welcome

Welcome to Anthem Blue Cross and Blue Shield!

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

If You need assistance in Spanish to understand this document, You may contact 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 healthcare Plan (the Plan) offered by Your Employer. You should please refer to 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 healthcare 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 Blue Cross and Blue Shield'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," is an independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc. Anthem has been designated by Your Employer to provide administrative services for Your Employer's Group Health Plan. These administrative services may include claims processing, care management, arranging a Network of healthcare Providers whose services are covered by the Plan, and other services.

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. Although Anthem is the Claims Administrator, 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.

Many words used in this Benefit Booklet have special meanings, like Covered Services, Network Provider, and Medical Necessity. These words are capitalized and are described in the **Definitions** section. Please refer to these definitions for the best understanding of what is being stated. Throughout this Booklet there may be references to "we," "us," "our," "You," and "Your." The words "we," "us," and "our" mean Anthem or any of its subsidiaries, affiliates, subcontractors, or designees. The words "You" and "Your" mean the Member, Subscriber, and each Covered Dependent.

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. TTY/TDD service also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

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 (Monday – Friday, 8:00 a.m. to 8:00 p.m.). It may be helpful for You to understand Your benefit coverage and any costs You may be responsible for prior to receiving care. Although a Provider may be part of Anthem's Provider Network, You may have a Deductible, Copayment, or other out-of-pocket expenses. 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 please refer to the section titled **Healthcare/Medical Management – Precertification**.

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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. Please refer to 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 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.

NOTE: Words and phrases within this document that are denoted with initial capitalization have the meaning ascribed to them within the document itself, or within the Definitions section.

The company reserves the right to amend or terminate the Plan at any time. You will be notified of any changes that affect Your benefits, as required by Federal law.

To receive the highest benefits at the lowest Out-of-Pocket cost, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, when You use an Out-of-Network Provider You may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please refer to the Claims Payment section for more details.

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

Financial Tools

Each Plan offers online financial tools to help You keep track of Your healthcare dollars. Plus, You can track Your claims for Covered Services. You can review what You've spent on healthcare, view Your balance, or look up the status of a particular claim any time of the day.

Coinsurance/Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's charge.

Maximum Employee Contributions to Your Health Savings Account this Benefit Period

For 2026, combined employee and employer contributions can be made to Your **Health Savings Account** up to the following:

Maximum Contributions to Your Health Savings Account	
Individual Coverage	$4,500
Family Coverage	$9,000

Schedule of Benefits	HealthSync	Network	Out-of-Network
Calendar Year Deductible			
Single	$3,000	$6,000	$7,500
Family	$6,000	$12,000	$15,000
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.			
Your Plan has a non-embedded Deductible which means: If You, the Subscriber, are the only person covered by this Plan, only the "Single" 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. For additional information about Your non-embedded Deductible, please refer to the **How Your Plan Works** section.			
Amounts satisfied toward the network calendar year Deductible will be applied toward the out-of-network calendar year Deductible and amounts satisfied toward the Out-of-Network calendar year Deductible will be applied toward the network calendar year Deductible.			
Coinsurance After the calendar year Deductible is Met (Unless Otherwise Specified)			
Plan Pays	80%	60%	40%
Member Pays	20%	40%	60%
Reminder: Except for Surprise Billing Claims, Your Coinsurance will be based on the Maximum Allowed Amount. If You use an Out-of-Network Provider, You may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Depending on the service, this difference can be substantial.			
Out-of-Pocket Maximum Per calendar year Includes Coinsurance and the calendar year Deductible. Does NOT include Precertification penalties, charges in excess of the Maximum Allowed Amount, Non-Covered Services or Out-of-Network Human Organ and Tissue Transplant Services.			
Single	$5,000	$8,000	$9,500
Family	$10,000	$16,000	$19,000
Individual Embedded	Not Applicable	$12,000	Not Applicable

Your Plan has a non-embedded Out-of-Pocket Maximum which means:
If You, the Subscriber, are the only person covered by this Plan, only the "Single" 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. Any one individual in a family has an individual embedded out-of-pocket maximum of $12,000 in-network.

Schedule of Benefits	HealthSync	Network	Out-of-Network
For additional information about Your non-embedded Out-of-Pocket Maximum, please refer to the **How Your Plan Works** section.			
Amounts satisfied toward the network Out-of-Pocket Maximum will be applied toward the Out-of-Network Out-of-Pocket Maximum and amounts satisfied toward the out-of-network Out-of-Pocket Maximum will be applied toward the Network Out-of-Pocket Maximum.			
Allergy Care			
Testing and treatment	20%	40%	60%
Ambulance Services			
Ambulance Services (when Medically Necessary) Land / Air	20%	20%	20% (See note below)
Note: Air Ambulance Services for non-Emergency ambulance services are subject to Medical Necessity review(s) by us. Please refer to the **Healthcare/Medical Management-Precertification** section for more information. For air Ambulance Services, Out-of-Network Providers cannot bill You for more than Your applicable Network Deductible, Coinsurance, and/or Copayment. Benefits for non-Emergency ground Ambulance Services are limited to $50,000 per trip if an Out-of-Network Provider is used. This limit does not apply to air Ambulance Services.			
Ambulance Services (when Medically Necessary) Ground	20%	20%	20% (See note below)
Note: 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. Benefits for non-Emergency ground Ambulance Services are limited to $50,000 per trip if an Out-of-Network Provider is used. This limit does not apply to air Ambulance Services.			
Biofeedback	20%	40%	60%

Cellular and 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.	Benefits are based on the setting in which Covered Services are received.
Clinical Trials Please refer to Clinical Trials in the Benefits section for further information.	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	Benefits are paid based on the setting in which Covered Services are received

Schedule of Benefits	HealthSync	Network	Out-of-Network
Dental & Oral Surgery/TMJ Services			
Accidental Injury to Natural Teeth • Accidental Dental is limited to $3,000 per accident; INN and OON combined	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	Benefits are paid based on the setting in which Covered Services are received
Oral Surgery/TMJ - Subject to Medical Necessity – excludes orthodontic treatment	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	Benefits are paid based on the setting in which Covered Services are received
Diabetes Maintenance/Education			
Office Professional	20%	40%	60%
Outpatient Professional	20%	40%	60%
Outpatient Institutional	20%	40%	60%
Nutritional Counseling for Diabetes Care	20%	40%	60%
Diabetic Supplies	20%	40%	60%
Diagnostic Physician's Services Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:			

Primary care Physician Coinsurance	20%	40%	60%
Specialist Physician Coinsurance	20%	40%	60%
Diagnostic X-ray and Lab – office or independent lab	20%	40%	60%
High Diagnostic Imaging (including MRIs, CAT scans)	20%	40%	60%
Emergency Room and Urgent Care			
Emergency room for an Emergency Condition	20%	20%	20% (See note below)
All other services	20%	20%	20% (See note below)
Use of the emergency room for non-Emergency Conditions	Not Covered	Not Covered	Not Covered
Urgent Care clinic visit for an Emergency Condition	20%	40%	60%
Note: Care received Out-of-Network for an Emergency Condition will be provided at the Network level of benefits if the following conditions apply: A medical or Mental 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			

Schedule of Benefits	HealthSync	Network	Out-of-Network
or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. As described in the Consolidated Appropriations Act of 2021 Notice in the Health Benefits Coverage Under Federal Law section, for Emergency Services, Out-of-Network Providers may only bill You for any applicable Copayments, Deductible, and Coinsurance and may not bill You for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined You are stable and followed the notice and consent process.			
Eye Care			
Office visit – medical eye care exams (treatment of disease or Injury to the eye)	20%	40%	60%
Hearing Care			
Office visit – Audiometric exam / hearing evaluation test	20%	40%	60%

Home Healthcare Services	10%	30%	50%
Private Duty Nursing		82 visits per calendar year, 164 visits per lifetime combined Network and Out-of-Network	
Hospice Care Services **(Includes Inpatient, Outpatient, Home and Respite Care)**	20%	40%	60%
Bereavement	20%	40%	60%
Hospital Inpatient Services – Precertification Required			
Room and board (Semiprivate or ICU/CCU)	20%	40%	60%
Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient Physical Therapy, etc.)	20%	40%	60%
Pre-Admission testing	20%	40%	60%
Physician Services:			
► Surgeon	20%	40%	60%
► Assistant Surgeon	20%	40%	60%

Schedule of Benefits	HealthSync	Network	Out-of-Network
► Anesthesiologist	20%	40%	60%
► Radiologist	20%	40%	60%
► Emergency Services	20%	40%	60%
► Pathologist	20%	40%	60%
Note: *Surgeons, anesthesiologist, radiologist, assistant surgeon, Emergency Services, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services.			
Mammograms (Outpatient diagnostic)	20%	40%	60%
Maternity and Reproductive Health Services			
Dependents (eligible spouses and children of the Subscriber) are covered under Your benefit Plan. Please refer to the Eligibility section for more information.			

Maternity Prenatal Visits Certain prenatal services are covered under the “Preventive Care” benefit, as required by law.	20%	40%	60%
Maternity Delivery Care For Inpatient deliveries, also see the “Inpatient Services” section.	20%	40%	60%
Maternity Postpartum Visits Certain antepartum/maternity care, including pre-pregnancy, prenatal, postpartum, and interpregnancy services are covered under the “Preventive Care” benefit, as required by law.	20%	40%	60%
Physician Hospital / Birthing Center Services (Precertification required)			
Physician’s services	20%	40%	60%
Newborn nursery services (well baby care)	20%	40%	60%
Circumcision	20%	40%	60%

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. For well newborns, no separate cost shares (deductible/CO-INSURANCE) should be applied. The charge is applied to the mother claims only. For sick newborns normal deductible and co-in amounts should be applied.

Schedule of Benefits	HealthSync	Network	Out-of-Network
Infertility Services			
Limited Coverage Diagnostic Services (Non-Covered Services include but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.)	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed

Abortion (Therapeutic Termination of Pregnancy)	20%	40%	60%
Your Plan includes benefits for a therapeutic abortion, which is an abortion permitted under Indiana law if, for reasons based upon the professional, medical judgment of the pregnant woman's physician: • The abortion is necessary when reasonable medical judgment dictates that performing the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life; • The fetus is diagnosed with a lethal fetal anomaly; or • The pregnancy is a result of "rape or incest"			
For Travel and Lodging information, please refer to the Travel Reimbursement section.			
Sterilization Services (Precertification required for Inpatient procedures)	20%	40%	60%
Sterilizations for women will be covered under the "Preventive Care" benefit. Please refer to that section in Benefits for further details.			
Vasectomy	20%	40%	60%
Medical Supplies and Equipment			
Medical Supplies	20%	40%	60%
Durable Medical Equipment	20%	40%	60%
Orthotics Foot and Shoe	20%	40%	60%
Prosthetic Appliances (external) (Precertification required) • Including Cochlear Implants • Including Bone Anchored Hearing Aids	20%	40%	60%
Wig Needed After Cancer Treatment Benefit Maximum One wig per Benefit Period network and out-of-network combined.	20%	40%	60%

Schedule of Benefits	HealthSync	Network	Out-of-Network
The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices, and supplies, wigs will be based on the Maximum Allowed Amount for a standard item that is Medically Necessary to meet Your needs. If You choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and You will be required to pay any costs that exceed the Maximum Allowed Amount. Please check with Your Provider or contact us if You have questions about the Maximum Allowed Amount.			
Mental Health/Substance Use Disorder			

Hospital Inpatient Services	20%	40%	60%
Outpatient Services	20%	40%	60%
Residential Treatment Facility	20%	40%	60%
Physician Services (In person and/or virtual)	20%	40%	60%
Intensive Outpatient Program (IOP) - Institutional	20%	40%	60%
Partial Hospitalization (PHP) - Institutional	20%	40%	60%
Note: A Virtual Visit is defined as Telehealth, Online, and Telemedicine.			
Telehealth - Consultations with Your physician (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet)	20%	40%	60%
LiveHealth Online – Virtual Visits (Mental Health and Substance Use Disorder)	20%	40%	Not Covered
Any limits for nutritional counseling will not apply if You receive care with the primary diagnosis of Mental Health and/or Substance Use Disorder. Limits and cost-shares for nutritional counseling will process according to the Mental Health and Substance Use Disorder benefit.			
Applied Behavioral Analysis (ABA) Therapy	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Note: Coverage for the treatment of mental health and substance use disorder conditions is provided in compliance with Federal law.			
Outpatient Hospital / Facility Services			
Outpatient Facility	20%	40%	60%
Lab and x-ray services	20%	40%	60%

Schedule of Benefits	HealthSync	Network	Out-of-Network
Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	20%	40%	60%

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 Surgery Center), 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.			
Office Surgery • Including anesthesia	20%	40%	60%
Prescription Injectables/Prescription Drugs Administered in the Physician's Office	20%	40%	60%
Physician Services (In-person and/or virtual)			
Primary Care Physician (In-person and/or virtual)	20%	40%	60%
Specialist Physician (In-person and/or virtual) **Note:** A Virtual Visit is defined as Telehealth, Online, and Telemedicine.	20%	40%	60%
LiveHealth Online **–** Virtual Visits (Medical Services)	20%	40%	Not Covered
Telehealth - Consultations with Your physician (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet)	20%	40%	60%
Preventive Services	Covered in full	Covered in full	60% (not subject to deductible)
Includes mammograms (preventive)			
Skilled Nursing Facility	20%	40%	60%
Maximum days		100 days per calendar year combined Network and Out-of-Network.	
Surgical Services	20%	40%	60%
Abortion (Therapeutic Termination of Pregnancy)	20%	40%	60%

Schedule of Benefits	HealthSync	Network	Out-of-Network

Your Plan includes benefits for a therapeutic abortion, which is an abortion permitted under Indiana law if, for reasons based upon the professional, medical judgment of the pregnant woman's physician:

- The abortion is necessary when reasonable medical judgment dictates that performing the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life;
- The fetus is diagnosed with a lethal fetal anomaly; or
- The pregnancy is a result of “rape or incest”

Gastric Bypass / Obesity Surgery When Medically Necessary. Precertification Required	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed	Covered at the benefit level of the services billed
Therapy Services (Outpatient)			
Physical Therapy – limited to 25 visits per calendar year, combined Network and Out-of-Network	20%	40%	60%
Occupational Therapy – limited to 25 visits per calendar year, combined Network and Out-of-Network	20%	40%	60%
Speech Therapy – limited to 25 visits per calendar year, combined Network and Out-of-Network	20%	40%	60%
Cardiac Rehabilitation	20%	40%	60%
Manipulation Therapy – limited to 12 visits per calendar year, combined Network and Out-of-Network	20%	40%	60%
Radiation Therapy	20%	40%	60%
Chemotherapy	20%	40%	60%
Respiratory Therapy	20%	40%	60%
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.			

Any limits for physical, occupational, and speech therapy will not apply if You receive care with the primary diagnosis of Mental Health and/or Substance Use Disorder. Limits and cost-shares for physical, occupational, and speech therapy will process according to the Mental Health and Substance Use Disorder benefit.

Schedule of Benefits	HealthSync	Network	Out-of-Network

Transplant Services		
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. **The requirements described below do not apply to** cornea 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 that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as a Network Transplant Provider by the Blue Cross and Blue Shield Association. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.) Benefits for Covered Services that are not part of the covered procedure will be based on the setting in which Covered Services are received. Please refer to the **Benefits** section for additional details. **Centers of Medical Excellence (CME) Transplant Providers** **Blue Distinction Center Facility**: Blue Distinction Facilities have met or exceeded national quality standards for care delivery. **Centers of Medical Excellence (CME)**: Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery. **Network Transplant Provider**: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. **Out of Network (PAR) Transplant Provider**: Providers participating in the Plan's Networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.	**Center of Medical Excellence/Network Transplant Provider**	**Out-of-Network Transplant Provider**
Covered Procedure Benefit Period for Network Providers The number of days or the applicable case rate / global time period will vary, depending on the type of covered procedure and the approved Network Provider agreement.		

Before and after the covered procedure Benefit Period, Covered Services will be covered as Inpatient services, outpatient services, home visits, or office visits, depending on where the service is performed. **Covered Procedure Benefit Period for All Other Providers** Not applicable – There is no unique Benefit Period for services from all other Providers.			
Care coordinated through a Network Transplant Provider/ Center of **Medical** Excellence – not subject to Deductible When performed by Out-of-Network Transplant Provider (subject to Deductible, does not apply to the Out of-Pocket Maximum). **You are responsible for any charges from the Out-of-Network Transplant Provider which exceeds the Maximum Allowed Amount.**			
Human Organ and Tissue Transplant Services (including, but not limited to, heart, lung, bone marrow & stem cell			
Inpatient Facility Services	20%	40%	60%
Inpatient Professional and Ancillary (non-Hospital) Services	20%	40%	60%
Outpatient Facility Services	20%	40%	60%
For Travel and Lodging information, please refer to the Travel Reimbursement section			
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) (Inpatient & Outpatient)	20%	40%	60%
Limited to $10,000 per transplant maximum combined Network and Out-of-Network **subject to Claims Administrator's approval.**			
All Other Covered Transplant Services	20%	40%	60%
Travel Reimbursement	20%	40%	60%
Unless prohibited by law, the Claims Administrator will cover reasonable and necessary travel costs when You are required to travel to another state to obtain Covered Services that are not available within Your state. Travel and Lodging Expenses may be available for some surgical procedures received at a Network Facility. The Plan will assist the patient and family with travel and lodging arrangements when the Member lives 50 miles from a Network Facility. Services must be received at a Network Facility. Deductible and other cost-shares may apply for travel and lodging benefits. Please contact Member Services at the number on the back of Your Identification Card to confirm Your benefits. Expenses for travel and lodging for the recipient and a companion should be verified by the Plan and may be available as follows:			

Schedule of Benefits	HealthSync	Network	Out-of-Network

- Transportation is covered, including expenses for personal car mileage at the current Federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the surgery for an evaluation, the procedure, or necessary post-discharge follow-up;
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 for one person or $100 a day for two people (a maximum of $50 per person — $100 for patient and companion combined — per night is paid toward lodging expenses; meals are not covered);
- Travel and lodging expenses are available only if the Member resides more than 50 miles from the Network Facility where services are received*;*
- If the patient is a Covered Dependent minor child, the transportation expenses of two companions will be covered; lodging expenses will be reimbursed at the $150 per-diem rate.
- These benefits are subject to a combined overall lifetime maximum of $10,000 per covered person, per calendar year, for all transportation and lodging expenses incurred by the Member receiving the service and companion (companions, if the Covered Dependent is a minor), and reimbursed under the Plan.
- For information about the transportation and lodging benefits, please contact Member Services at the number on the back of Your Identification card.

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.

Note: Prescription Drugs that the Plan is required to cover by Federal law under the “Preventive Care” benefit will be covered with no Deductible, Copayments, or Coinsurance when a Network Provider is used.

TOTAL HEALTH AND WELLNESS SOLUTION

Components of the health Plan include state contracted disease management, population health management, and pharmacy benefit managers with whom PHI is shared under the protection of HIPAA Business Associate Agreements.

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 healthcare services. A staff of experienced nurses is trained to address common healthcare concerns, such as medical triage, education, access to healthcare, 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 Audio Health 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.

Anthem Image Shopper

This Program provides You with access to important information about imaging services You might need.

If You need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where You go to receive the service. Sometimes the differences are significant – anywhere from $300 to $3,000 – but a higher price doesn't guarantee higher quality. If Your benefit Plan requires You to pay a portion of this cost (like a Deductible or Coinsurance), where You go can make a very big difference to Your wallet.

How the program works

- Your doctor lets Anthem know You will have one of these procedures.
- If the procedure was ordered at a Hospital-based Facility, Anthem will check to see if there are non-Hospital-based Facilities near You with Providers who could perform the procedure and offer a lower cost for the service.
- If a non-Hospital Facility is available, Anthem may call You to give You other choices nearby.
- You choose the Provider that best meets Your needs, whether it's the one Your doctor suggested, or one Anthem tells You about. It's completely up to You!

Sleep Study Program

Your Plan includes benefits for a Sleep Management Program, which is a program that helps Your Physician make better informed decisions about Your treatment. The Sleep Management Program includes outpatient and home sleep testing and therapy. If You require sleep testing, depending on Your medical condition, You may be asked to complete the sleep study in Your home. Home sleep studies provide the added benefit of reflecting Your normal sleep pattern while sleeping in the comfort of Your own bed versus going to an outpatient Facility for the test.

As part of this program, You are required to obtain Precertification for:

- Home sleep tests (HST)
- In-lab sleep studies (polysomnography or PSG, a recording of behavior during sleep)
- Titration studies (to determine the exact pressure needed for treatment)
- Treatment orders for equipment, including positive airway pressure devices (APAP, CPAP, BPAP, ASV), oral devices and related supplies.

If You need ongoing treatment, we will review Your care quarterly to assure that medical criteria are met for coverage. Your equipment supplier or Your Physician will be required to provide periodic updates to ensure clinical appropriateness. Ongoing claim approval will depend partly on how You comply with the treatment Your Physician has ordered.

Please talk to Your Physician about getting approval for any sleep testing and therapy equipment and supplies.

If You have questions about Your care, please talk with Your Physician. For questions about Your Plan or benefits, please call Member Services.

Musculoskeletal and Pain Management
The Musculoskeletal and Pain Management program can help You and Your doctor make the best decision so You can get the right care in the right place. As part of this new program, Prior Authorization will be required to help you understand the treatment options and requirements for Plan coverage before You have joint surgery or spinal pain treatment. If You have a musculoskeletal condition, Your doctor must contact Anthem before scheduling any of the following:

- Spine, hip, knee, or shoulder joint surgery; and
- Spinal pain treatment, such as spinal pain injections, epidurals, nerve blocks, ablations, thermal destruction of the intervertebral disc, or use of spinal stimulators.

Your doctor can contact Anthem through our Provider portal or by calling the number for Image/Cardio/Sleep/Genetic/Ortho on Your Identification Card. Here's what happens next:

1. Your treatment will be reviewed by orthopedic, neurosurgical, and pain Specialists using state-of-the-art clinical criteria and considering Your benefits.
2. The review may also include a phone call between one of our Specialists and Your doctor to help determine the right test, the right treatment, and the right place for Your care.

After the review, Your doctor will talk to You about Your treatment options.

HealthSync Designated Orthopedic Network
As part of the Anthem HealthSync plan, you have to access to a HealthSync Designated Orthopedic Network of facilities specifically developed for hip and knee replacement (for your primary procedure and/or revision surgery). The special HealthSync Designated Network ensures you can receive high quality care, and competitive cost.

Starting January 1, 2026, Anthem HealthSync plan members will be directed to HealthSync Designated Network facilities for hip and knee procedures, where they can benefit from coordinated care, advanced resources, and trusted specialists.

Should you need a hip or knee replacement and/or revision, your care will be directed to one of Anthem's HealthSync Designated Orthopedic Network facilities to ensure the best outcome. Members living over 100 miles away from a HealthSync Designated Network Facility are exempt and will not be required to utilize the HealthSync Designated Orthopedic Network, they may choose to see an in-network HealthSync provider.

Learn more about the network by calling the number on the back of your member ID card to discuss your needs and see if your suggested procedure is eligible for coverage.

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 50 miles from Your residence to reach the Facility where your covered inpatient or outpatient orthopedic surgical procedure will be performed. The Plan's assistance with travel expenses includes ground transportation to and from the Facility and lodging for the Orthopedic 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.

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 healthcare supplies.

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. **Note:** Coverage for the treatment of mental health and substance use disorder conditions within this program is provided in compliance with Federal law.

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.

Sydney Health

Discover a powerful and more personalized health app. View all Your benefits and access wellness tools to improve Your overall health with the Sydney Health app.

The Sydney Health mobile app works with You by guiding You to better overall health — and for You by bringing Your benefits and health information together in one convenient place. Sydney Health has everything You need to know about Your benefits, so You can make the most of them while taking care of Your health.

Working with You

- Reminding You about important preventive care needs
- Guiding You with insights based on Your history and changing health needs
- Empowering You with personalized tools to find and compare healthcare Providers and check costs

Working for You Giving You instant access to Your vision and dental benefits

- Storing Your Member Identification Card so You can show, email, or fax it right from Your phone
- Providing answers quickly through real-time live chat with Anthem Health Guides and nurses
- Connecting You directly to care through a symptom checker, a virtual video or text visit.

Total Health Total You

With Your unique health Plan Total Health, Total You, helpful benefits and health information are always at Your fingertips. Through an app called Sydney Health, You can chat with a member services Health Guide about claims or health questions, keep track of healthcare spending, find Network doctors and Urgent Care centers, or use online wellness tools. Total Health, Total You can also help You:

- Manage pain or chronic conditions, like asthma or diabetes
- Understand Your medications and Prescriptions
- Navigate hospital stays or major medical decisions
- Work through a difficult life situation—such as depression or a death in the family
- Stay healthy through wellness resources
- We have a team ready to help—from nurses to social workers, dietitians, respiratory therapists, pharmacists, exercise physiologists, and more

It's all included in Your Plan, at no cost to You. Reach out to a supportive member services Health Guide and download the Sydney Health app by searching "Sydney Health" in the App store or Google Play Store.

Cancer Care Engagement

Cancer Care Engagement provides high-risk cancer patients with critical, comprehensive support through telephonic and digital engagements through concierge care. This program seamlessly integrates existing cancer care offerings and optimizes access to key resources to simplify the Member's experience. Our professional team of care navigators take full advantage of our expansive network and strong Provider relationships, so Members will receive the right care when necessary.

Cancer Care Engagement is designed for Members undergoing chemotherapy who have a high risk for adverse effects. This program is designed to help with:

- Reducing emergency room admissions.
- Lowering Member's cost of care.

- Providing Members with access to a dedicated care team at any time, day or night, throughout treatment.
- Offering additional care like behavioral health support and medication management.

Building Healthy Families

This digital program can help support Your family from preconception through the stages of pregnancy, childbirth, and early childhood (to age 5 and beyond). It is available 24/7 through our Sydney Health mobile app, and at www.anthem.com, and features an extensive content library covering topics to support diverse families, including single parents and same-sex or multicultural couples. In addition, the app features many tools including fertility, diaper change, and feeding trackers, due date calculators, and blood pressure monitoring. Visit the Sydney Health app or www.anthem.com to enroll today.

ELIGIBILITY

For the State employee Plans, “eligibility” is defined as:

- All active “full time” state employees and their eligible “dependents”. For this purpose, “full-time” means the lesser of:

(a) 37.5 hours per week.

(b) The number of hours established as a matter of federal preemption.

For employees of the Senate or House of Representative, “eligibility” is defined as “full-time” employees, with “full-time” determined by the President Pro Tempore or Speaker of the House.

- All appointed or elected officials and their eligible “dependents”.

- Employees eligible under the Short- and Long-Term Disability Program remain eligible during the period of disability.

- "Dependent” means:

(a) Spouse of an employee;

(b) Any children, stepchildren, foster children, legally adopted children of the employee or spouse, or children who reside in the employee’s home:

i. for whom the employee or spouse has been;

I. appointed legal guardian or

II. awarded legal custody

by a court, or

ii. in an I.C 31-19-7-1 approved placement for purposes of adaption, under the age of twenty-six (26). In the event a child was defined as a “dependent”, prior to age 19, and meets the following disability criteria, prior to age 19:

(I) is incapable of self-sustaining employment by reason of mental or physical disability,

(II) resides with the employee at least six (6) months of the year, and

(III) receives 50% of his or her financial support from the parent

such child’s eligibility for coverage shall continue if satisfactory evidence of such disability and dependency is received by Contractor in accordance with Contractor’s disabled dependent certification and recertification procedures. Eligibility for coverage of the “Dependent” will continue until the employee discontinues his coverage or the disability no longer exists. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires periodic documentation from a physician after the child’s attainment of the limiting age.

- A group health coverage program that is equal to that offered active employees shall be provided by the State for each “Retired Legislator”, dependent or spouse as defined and pursuant to the conditions set forth in IC 5-10-8.

- “Retirees” meeting the following criteria will continue to be eligible until they become eligible for Medicare:

(a) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;

(b) Must have completed twenty (20) years of public service, ten (10) years of which must be

continuous State service immediately preceding retirement;

(c) Must have fifteen (15) years of participation in a retirement fund.

- "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

  (a) Must retire after December 31, 2006;

  (b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;

  (c) Must have completed fifteen (15) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement.

- "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

  (a) Must have been employed as a teacher in a State institution under IC 11-10-5, IC 12-24-3, IC 16-33-3, or IC 16-33-4;

  (b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;

  (c) Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement.

- A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:

  (a) Retirement date is after June 30, 1990;

  (b) Will have reached the age of sixty-two (62) on or before retirement date;

  (c) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;

  (d) Who has at least eight (8) years of service credit as a participant in the Judge's retirement fund, with at least eight (8) years of service credit completed immediately preceding the Judge's retirement.

- A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:

  (a) Who is a retired participant under the Prosecuting Attorney's Retirement fund;

  (b) Whose retirement date is after January 1, 1990;

  (c) Who is at least sixty-two (62) years of age;

  (d) Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and

  (e) Who has at least ten (10) years of service credit as a participant in the Prosecuting Attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.

- Retirees eligible under subsections 6 - 10 must file a written request for the coverage within ninety (90) days after retirement. At that time, the retiree may elect to have the retiree's spouse covered. The spouse's subsequent eligibility to continue insurance under the surviving spouse's eligibility end on the earliest of the following:

  (a) Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the Spouse would be eligible to remain covered until the end of the maximum period under COBRA;

  (b) When the Spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;

(c) The end of the month following remarriage; or
(d) As otherwise provided by Act of the General Assembly.

- Employee on a leave of absence for ninety (90) days or less and out of pay status.
- An employee on family medical leave.
- Retirees eligible under IC 5-10-12.
- As otherwise provided by Act of the Indiana General Assembly.

Continuation of Health Benefits While in Out-Of-Pay Status
When You are in out-of-pay status, coverage will continue through the duration of the approved leave of absence with no lapse in coverage for up to 6 pay periods. When returning to in-pay status, premiums missed during the time spent out-of-pay status will be paid through payroll deductions. In the event payroll deductions cannot occur or You are in an out-of-pay status for more than four (4) consecutive pay periods, You will be invoiced directly at home by the State Personnel Benefits Division for premiums owed. You will be given thirty (30) days to provide payment from the date of the invoice. Failure to submit payment will result in the debt being recovered through Your Indiana State Tax Refund or sent to the Attorney General's Office for collection.

Effective Date Of Your Coverage
"For specific information concerning Your Effective Date of coverage under this Plan, You should please refer to Your Human Resources or benefits department."
Coverage for a newborn child is effective from the moment of birth. Covered Services include the treatment of any injury or illness such as congenital deformity, hereditary complication, premature birth, and routine nursery care. Newborn must be formally added to Employee's policy through "family status" change process. Please refer to NEWBORN INFANT COVERAGE.

Newborn Infant Coverage
The benefits payable for covered Dependent children shall be paid for a sick or injured newborn infant of a Covered Person for the first 30 days of his or her life. The coverage for newly adopted children will be the same as for other covered Dependents. The coverage for the newborn infant or newly adopted child consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage for the newborn infant or newly adopted child shall include, but not be limited to, benefits for Inpatient or Outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

The coverage required for a newly adopted child:

1. Is effective upon the earlier of:
    a) The date of placement for the purpose of adoption; or
    b) The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption.

2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or

3. Continues unless required action as described below is not taken.

To be covered beyond the first 30 days, the newborn or newly adopted child must be added to the Covered Person's Plan Enrollment within the first 30 days after birth or adoption.

If the Enrollee must change to coverage with a higher fee to add the child, the Enrollee will be liable for the higher fee for the entire period of the child's coverage, including the first 30 days.

Federal Laws Related To Your Coverage

In the past few years, Congress has passed several laws that have affected our group health Plans. These laws are designed to reduce Medicare expenditures by requiring that active employees and/or their Dependents who are either age 65 or over, or disabled to elect either:

a) our group health Plan; or
b) Medicare as their primary coverage.

The preference is option (a) since option (b) would require the discontinuance of the group medical Plan. In addition, Medicare no longer requires enrollment in the Part B Supplemental Medical Insurance Benefit for which there is a charge so long as You remain covered under our group medical Plan.

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 Health Savings Account (HSA), 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. To find a Network Provider for this Plan, please refer to "How to Find a Provider in the Network," later in this section**.**

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.

If You receive Covered Services from an Out-of-Network Provider after we failed to provide You with accurate information in our Provider directory at www.anthem.com, or after we failed to respond to Your telephone or web-based inquiry within the time required by Federal law, Your cost-share for Covered Services will be based on the network level.

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 Mental health Providers.

If You receive Covered Services from an Out-of-Network Provider after we failed to provide You with accurate information in our Provider directory at anthem.com, or after we failed to respond to Your telephone or web-based inquiry within the time required by Federal law, Covered Services will be covered at the Network level.

To see a Physician, call their office:

- tell them You are an Anthem Member,
- have Your Member Identification Card handy. The Physician'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. (Please refer to the **Healthcare/Medical Management – Precertification** section for further details.)

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

After Hours Care

If You need care after normal business hours, Your Physician may have several options for You. You should call Your Physician'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. If You are experiencing a Mental Health crisis, You may also call 988 for assistance.

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:

- There is no limit to what an Out-of-Network provider can charge unless Your claim involves a Surprise Billing Claim;
- The Out-of-Network Provider may charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance unless Your claim involves a Surprise Billing Claim;
- You may have higher cost-sharing amounts (i.e., Deductibles and/or Coinsurance) unless Your claim involves a Surprise Billing Claim;
- 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 refer to **Healthcare/Medical Management – Precertification** for more details.)

Surprise Billing Claims

Surprise Billing Claims are described in the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section. Please refer to that section for further details.

Use the Mobile App to Connect with Us

As soon as You enroll in this Plan, You should download the mobile app (Sydney Health). You can find details on how to do this at www.anthem.com**.** The goal is to make it easy for You to find answers to Your questions. You can chat with a representative live in the app, or contact us at www.anthem.com.

How to Find a Provider in the Network

There are several 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.

- Please refer to Your Plan's directory of Network Providers at www.anthem.com, which lists the Physicians, Providers, and Facilities that participate in this Plan's Network. The provider tier can be identified by selecting the "recognitions/tier" link within the provider search tool.
- Search for a Provider in our Sydney Health app.
- Call Member Services to ask for a list of Physicians and Providers that participate in this Plan's Network, based on specialty and geographic area. Member Services can help You determine the Provider's name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.
- Check with Your Physician or Provider.

If You need details about a Provider's license or training, or help choosing a Physician 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.

Continuation of Care

If Your Network Provider leaves our network for any reason other than termination for cause, retirement, or death, and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still get network benefits. "Active treatment" includes:

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

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

In these cases, You may be able to continue seeing that Provider until treatment is complete, or for 90 days, whichever is shorter. If You wish to continue seeing the same Provider, You should contact Member Services for details. Any decision by the Plan regarding a request is subject to review.

The BlueCard Program

Like all Blue Cross and 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 refer to "Inter-Plan Programs" in the **Claims Payment** section.

Identification Card (ID Card)

We will provide a Digital Identification Card to each Member enrolled in the Plan (physical cards available upon request). When You receive care, You may be asked to share details from Your Identification Card. Only covered Members have the right to services or benefits under this Benefit Booklet. If anyone receives services or benefits to which they are not entitled to under the terms of this Benefit Booklet, they must pay for the actual cost of the services.

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

Calendar Year Deductible

Before the Plan begins to pay benefits, you must meet any Deductible required. You must satisfy the Deductible based on the Network tier being utilized as explained in the Schedule of Benefits. Deductible requirements are stated in the Schedule of Benefits.

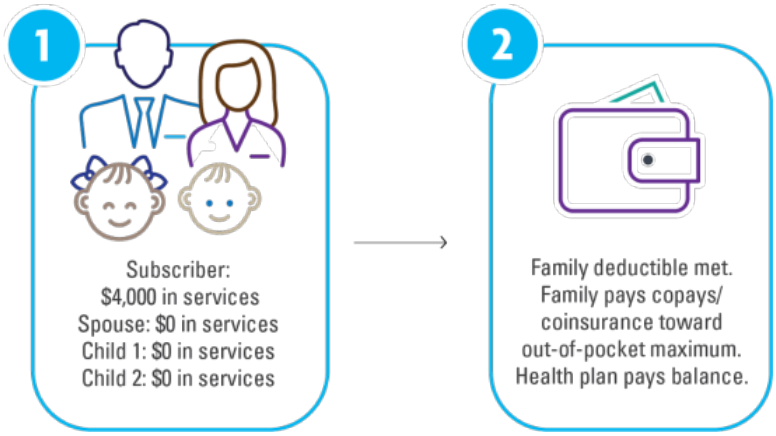
Deductibles

There are two different types of Deductibles, embedded and non-embedded (True Family) Deductibles. Your Plan has a non-embedded Deductible.

Non-embedded Deductible

The non-embedded (true family) Deductible means that a family can meet the Deductible by pooling Deductible expenses. Unlike embedded Deductible Plans, **there is no limit to the amount one Member can pay toward the family Deductible**.

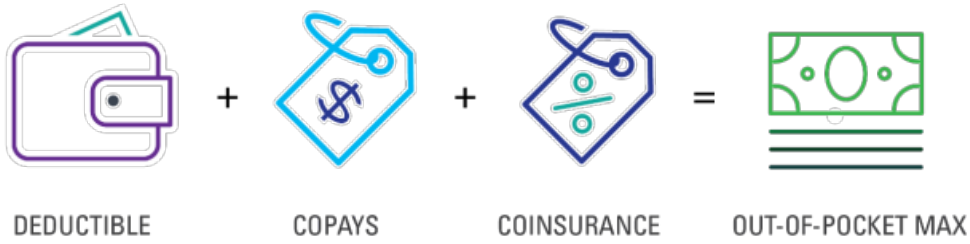
The following is an **example** that may not align with Your benefits. If You have a $2,000/$4,000 (single/family) non-embedded (true family) Deductible, here is how Your Plan would work:



In this example, the subscriber met the entire family Deductible, so the entire family moves on to Copays/Coinsurance for Covered Services.

Out-of-Pocket Maximum

An Out-of-Pocket Maximum is the annual limit on the amount of money that You would have to pay for healthcare services, not including monthly premiums or services not covered. After the maximum is reached, all covered health services are paid in full by the health Plan for the rest of that Plan Year.

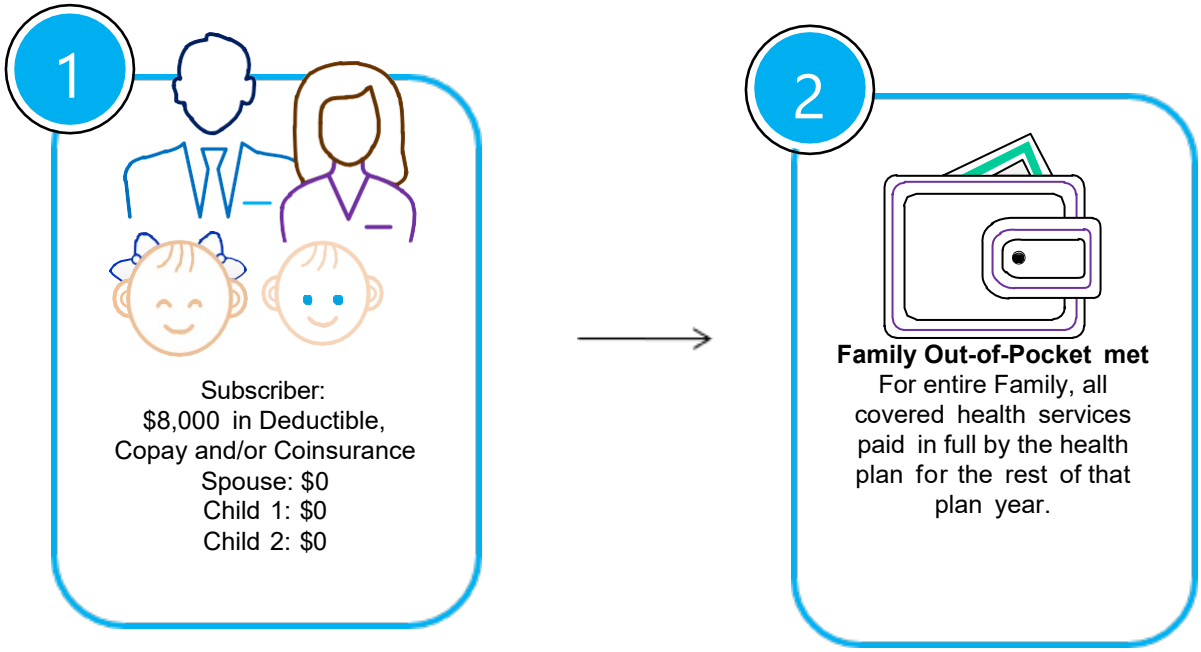


All payments that apply to the Deductible also apply to the Out-of-Pocket Maximum.

Non-Embedded (True Family) Out-of-Pocket Maximum

The non-embedded (true family) Out-of-Pocket means that a family can meet the Out-of-Pocket by pooling Out-of-Pocket expenses. **However, your plan has an individual embedded out-of-pocket maximum on the family coverage, which means any individual in a family is limited to an out-of-pocket maximum of $10,600 in-network.**

The following is an **example** that may not align with Your benefits. If You have a $4,000/$8,000 (single/family) non-embedded (true family) Out-of-Pocket. here is how Your Plan would work:



In this example, the subscriber met the entire family Out-of-Pocket, so the entire family moves on to all covered health services paid in full by the health Plan for the rest of that Plan Year.

Once the out-of-pocket is met, You will pay no cost-share when You receive Covered Services.

HEALTHCARE/MEDICAL 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 healthcare 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 healthcare Providers from a range of medical and surgical specialties. The Acute Care at Home Programs are separate from our Home Healthcare 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 healthcare 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. 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 healthcare services, (e.g., Home healthcare 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 should tell the Claims Administrator of the admission as soon as possible. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

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

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

- **Post-service Review –** A review of a service, treatment, or admission for a benefit coverage determination 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.

Failure to Obtain Precertification Penalty:

Important Note: If You or Your Out-of-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 Inpatient Facility services from a Network or BlueCard Provider.

The following list is not all inclusive and is subject to change. Limitations and exclusions may apply, depending on Your Plan's Covered Services. Please call the Member Services telephone number on Your Identification Card to confirm if the service or procedure is covered under Your Plan.

2027 Precertification List

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 (Precertification is not required. However, Plan notification should be provided as soon as possible.)

Diagnostic Testing:

- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability and Congenital Anomalies
- Genetic Testing for Inherited Diseases
- Genetic Liquid Biopsy in the Management of Cancer and Cancer Surveillance
- Preimplantation Genetic Diagnosis Testing
- Prostate Saturation Biopsy
- Somatic Tumor Testing
- Testing for Biochemical Markers for Alzheimer's Disease
- Whole Genome Sequencing, Whole Exome Sequencing, Gene Panels, and Molecular Profiling
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders

Durable Medical Equipment (DME)/Prosthetics:

- Augmentative and Alternative Communication (AAC) Devices with Digitized or Synthesized Speech Output
- Brain Computer Interface Rehabilitation Devices
- Compression Devices for Lymphedema
- Electric Tumor Treatment Field (TTF)
- External Upper Limb Stimulation for the Treatment of Tremors
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)

- High Frequency Chest Compression Devices for Airway Clearance
- Home Video Assisted Robotic Rehabilitation Systems
- Implantable Infusion Pumps
- Intrapulmonary Percussive Ventilation (IPV) Device
- Microprocessor Controlled Lower Limb Prosthesis
- Myoelectric Upper Extremity Prosthetic Devices
- Neuromuscular Electrical Training for the Treatment of Obstructive Sleep Apnea or Snoring
- Noninvasive Electrical Bone Growth Stimulation of the Appendicular Skeleton
- Robotic Arm Assistive Devices
- Standing Frames
- Ultrasound Bone Growth Stimulation
- Pneumatic Compression Devices for Prevention of Deep Vein Thrombosis of the Extremities in the Home Setting
- Powered Robotic Lower Body Exoskeleton Devices
- Powered Wheeled Mobility Devices

Gender-Affirming Surgery

- If the benefit is covered, Precertification is required.

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:
  - Donor Leukocyte Infusion
  - Intrathecal treatment of Spinal Muscular Atrophy (SMA) Spinraza (nusinersen)
  - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
  - (CAR) T-cell immunotherapy treatment, including, but not limited to:
    - Adstiladrin (nadofaragene firadenovec-vncg)
    - Aucatzyl (obecabtagene autoleucel)
    - Axicabtagene ciloleucel (Yescarta™)
    - Amtagvi (lifileucel)
    - Brexucabtagene Autoleucel (Tecartus)
    - Carvykti (ciltacabtagene autoleucel) (CAR-T)
    - Ldecabtagene vicleucel (Abecma)
    - Lisocabtagene maraleucel (Breyanzi)
    - Papzimeos (zopapogene imadenovec-drba)
    - Revcovi (elapegademase-lvlr)
    - Tecelra (afamitresgene autoleucel)
    - Tisagenlecleucel (Kymriah™)
  - Gene Replacement Therapy (If the benefit is covered, Precertification is required). Including, but not limited to:
    - Allogeneic Bone Marrow-Derived Mesenchymal Stromal Cell Therapy
    - Autologous Cell Sheet-Based Gene Therapy for Treatment of Dystrophic Epidermolysis Bullosa
    - Defined Composition Cellular Immunotherapy for Select Leukemias or Myelodysplastic Syndrome
    - Encapsulated Cell Therapy for Degenerative Ocular Disease
    - Gene Therapy for Aromatic L-Amino Acid Decarboxylase Deficiency (Kebilidi™)
    - Gene Therapy for Beta Thalassemia Betibeglogene autotemcel (ZYNTEGLO)

- Gene Therapy for Cerebral Adrenoleukodystrophy (CALD)
- Gene Therapy for Duchenne Muscular Dystrophy
- Gene Therapy for Hemophilia
- Gene Therapy for Metachromatic Leukodystrophy
- Gene Therapy for Ocular Conditions/ Voretigene neparvovec-rzyl (Luxturna™)
- Gene Therapy for Severe Leukocyte Adhesion Deficiency-I
- Gene Therapy for Spinal Muscular Atrophy/ onasemnogene abeparvovec-xioi (Zolgensma®)
- Gene Therapy for Sickle Cell Disease
- Gene Therapy for Treatment of Hearing Loss
- Gene Therapy for Wiskott-Aldrich Syndrome

Mental Health/Substance Use Disorder (MH/SUD):
Precertification Required

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Residential Care
- Behavioral Health in-home Programs
- Applied Behavioral Analysis (ABA)*
- Intensive Outpatient Therapy (IOP)**
- Partial Hospitalization (PHP)**

*Precertification for ABA is recommended and applies unless the group specifically opts out of clinical review for this benefit. Retrospective review is allowed.

** Please check benefits for any exclusions, or specific Precertification requirements.

Other Outpatient and Surgical Services:

- Aduhelm (aducanumab)
- Ablative Techniques as a Treatment for Barrett's Esophagus
- Allogeneic, Xenographic, Synthetic Bioengineered, and Composite Products for Wound Healing and Soft Tissue Grafting
  - Insertion/injection of prosthetic material collagen implants
- Ambulance Services: Air and Water (excludes 911 initiated emergency transport)
- Autologous Fat Grafting and Injectable Soft Tissue Fillers
- Axial Lumbar Interbody Fusion
- Balloon Sinus Ostial Dilation
- Bariatric Surgery and Other Treatments for Clinically Severe Obesity (If the benefit is covered, Precertification is required.)
- Blepharoplasty, Blepharoptosis Repair, and Brow Lift
- Bone-Anchored and Bone Conduction Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, and other Breast Procedures
- Bronchial Thermoplasty
- Cardiac Contractility Modulation Therapy
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Cardioverter Defibrillator
- Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty
- Cellular Therapy Products for Allogeneic Stem Cell Transplantation Cervical and Thoracic Discography

- Cochlear Implants and Auditory Brainstem Implants
- Corneal Collagen Cross-Linking
- Cosmetic and Reconstructive Services: Skin Related, including, but not limited to:
    - Brachioplasty
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Procedures Performed on the Face, Jaw, or Neck (including facial dermabrasion, scar revision)
- Cosmetic and Reconstructive Services of the Trunk and Groin, including, but not limited to:
    - Brachioplasty
    - Buttock/Thigh Lift
    - Congenital Abnormalities
    - Lipectomy/Liposuction
    - Repair of Pectus Excavatum/Carinatum
    - Procedures on the Genitalia
- Cosmetic and Reconstructive Services of the Head and Neck, including, but not limited to:
    - Facial Plastic Surgery Otoplasty - Rhinophyma
    - Rhinoplasty or Rhinoseptoplasty (procedure which combines both rhinoplasty and septoplasty)
    - Rhytidectomy (Face lift)
    - Cranial Nerve Procedures
    - Ear or Body Piercing
    - Frown Lines
    - Neck Tuck (Submental Lipectomy)
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems
- Doppler-Guided Transanal Hemorrhoidal Dearterialization (THD)
- Electrophysiology-Guided Noninvasive Stereotactic Cardiac Radioablation
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
- Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
- Focal Laser Ablation for the Treatment of Prostate Cancer
- Functional Endoscopic Sinus Surgery (FESS)
- Home Parenteral Nutrition
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Immunoprophylaxis for respiratory syncytial virus (RSV)/ Synagis (palivizumab)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implantable Infusion Pumps
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Implanted Devices for Spinal Stenosis
- Implanted Artificial Iris Devices
- Implanted Port Delivery Systems to Treat Ocular Disease
- Implantable Peripheral Nerve Stimulation Devices as a Treatment for Pain
- Implantable Shock Absorber for Treatment of Knee Osteoarthritis Intracardiac Ischemia Monitoring
- Implantation of Occipital, Supraorbital or Trigeminal Nerve Stimulation Devices (and Related Procedures)
- Internal Rib Fixation Systems

- Interspinous Process Fixation Devices
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Irreversible Electroporation
- Leadless Pacemaker
- Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia
- Mastectomy for Gynecomastia
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- Meniscal Allograft Transplantation of the Knee
- Minimally Invasive Treatment of the Posterior Nasal Nerve to Treat Rhinitis
- Nasal Valve Repair
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Panniculectomy and Abdominoplasty
- Partial Left Ventriculectomy
- Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention
- Penile Prosthesis Implantation
- Percutaneous and Endoscopic Spinal Surgery
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- Perirectal Spacers for Use During Prostate Radiotherapy
- Private Duty Nursing in the Home Setting (If the benefit is covered, Precertification is required.)
- Reduction Mammaplasty
- Renal Denervation for Hypertension
- 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
- Sacroiliac Joint Fusion, Open
- Self-Expanding Absorptive Sinus Ostial Dilation
- Sipuleucel-T (Provenge®) Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Surgical and Ablative Treatments for Chronic Headaches
- Therapeutic Apheresis
- Total Ankle Replacement
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins
- Transcatheter Mitral, Pulmonary, and Tricuspid Heart Valve Procedures
- Transendoscopic Therapy for Gastroesophageal Reflux Disease, Dysphagia, and Gastroparesis
- Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects

- Treatment of Osteochondral Defects
- Treatment of Temporomandibular Disorders
- Treatment of Varicose Veins and Superficial Venous Insufficiency
- Treatments for Urinary Incontinence
- Ultrasound Ablation for Oncologic Indications
- Vagus Nerve Stimulation
- Vascular Embolization and Occlusion Procedures
- Venous Angioplasty with or without Stent Placement/Venous Stenting
- Viscocanalostomy and Canaloplasty
- Wireless Cardiac Resynchronization Therapy for Left Ventricular Pacing
- Wearable Cardioverter-Defibrillator

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.)

Radiation Therapy/ Radiology Services
- Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver
- Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver
- Intensity Modulated Radiation Therapy (IMRT)
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Myocardial Strain Imaging
- Proton Beam Therapy
- Radioimmunotherapy and Somatostatin Receptor Targeted Radiotherapy (Azedra, Lutathera, Pluvicto, Zevalin)
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Xofigo (Radium Ra 223 Dichloride)

Services not requiring Precertification for coverage, but recommended for pre-determination of Medical Necessity due to the existence of post service claim edits and/or the potential cost of services to the member if denied by Anthem for lack of Medical Necessity:

Procedures, equipment, and/or specialty infusion Drugs which have Medically Necessary criteria determined by Corporate Medical Policy or Adopted Clinical Guidelines.

Utilizing an Out-of-Network Provider may result in significant additional financial responsibility for You. Except for Surprise Billing Claims, if You use an Out-of-Network Provider, You may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount. Depending on the service, this difference can be substantial.

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.

Please contact us at the Member Services telephone number on the back of your Identification Card to determine if a Prior Authorization or a Precertification is required. You can find the list of medical services that require Precertification here: https://www.anthem.com/provider/prior-authorization/. Prescription Drugs requiring Prior Authorization can be found in the formulary list here: https://www.anthem.com/pharmacy-information

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, GA, IN, KY, ME, MO, NH, NV, NY, OH, VA, WI); Anthem Blue Cross (CA); 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	• The Provider must get Precertification when required
BlueCard 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)**	• Member must get Precertification when required or work with Your Provider to assist in obtaining Precertification. Call Member Services at the number on the back of Your Identification Card. • 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, not an emergency, or any charges in excess of the Maximum Allowed Amount. • **BlueCard Providers must obtain Precertification for all Inpatient admissions.**
Out-of-Network/ Non-Participating	Member	• Member must get Precertification when required or work with Your Provider to assist in obtaining Precertification. Call Member Services at the number on the back of Your Identification Card. • 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, not an emergency, or any charges in excess of the Maximum Allowed Amount.
NOTE: For an Emergency Care admission, Precertification is not required. However, You, Your authorized representative, **or doctor should tell the Claims Administrator as soon as You are possible.**		

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 please refer to 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	**Time frame 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
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**.**

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 healthcare 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 healthcare 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.

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. This also includes services rendered by an Emergency Medical Services Provider Organization within their scope of practice, performed or provided as advanced life support services, and performed or provided during a response initiated through the 911 system regardless of whether the patient is transported. If multiple Emergency Medical Services Provider Organizations qualify and submit a claim to Us, We:
  - May reimburse for one (1) claim per patient encounter; and
  - Reimburse the claim submitted by the Emergency Medical Services Provider Organization that performed or provided the majority of advanced life support services to You.

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 may be 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 may be 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.

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.

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.**

Cellular and Gene Therapy Services
Your Plan includes benefits for cellular and gene therapy services when Anthem approves the benefits in advance through Precertification. Please refer to the **Healthcare/Medical Management** – **Precertification** section 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 cellular and gene therapy services. Please call us to find out which Providers are approved Providers.

Services Not Eligible for Coverage
Your Plan does not include benefits for the following:

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

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 Healthcare Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

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

Your Plan may require You to use 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.

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 healthcare professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

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 (DME), Medical Devices, and Supplies
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.
- it is related to the Member's physical disorder.

Equipment, devices, supplies, and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices, and supplies, wigs will be based on the Maximum Allowed Amount for a standard item that is Medically Necessary to meet Your needs. If You choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and You will be required to pay any costs that exceed the Maximum Allowed Amount. Please check with Your Provider or contact us if You have questions about the Maximum Allowed Amount.

Emergency Services

If You are experiencing an emergency, please call 911 or visit the nearest Hospital for treatment. If You are experiencing a Mental Health crisis, You may also call 988 for assistance.

Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room or freestanding emergency Facility care, including a medical or Mental 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 Medical Condition; and within the capabilities of the staff and Facilities available at the Hospital, such further medical or Mental Health examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan. Emergency Services may also include necessary services, including observation services, provided as part of the emergency visit regardless of the department in which the services are provided.

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Medically Necessary services will be covered whether You get care from a Network or Out-of-Network Provider. Emergency Care You get from an Out-of-Network Provider will be covered as a Network service and will not require Precertification. For Surprise Billing Claims, the Out-of-Network Provider can only charge You any applicable Deductible, Coinsurance, and/or Copayment and cannot bill You for the difference between the Maximum Allowed Amount and their billed charges until Your condition is stable and the Out-of-Network Provider has complied with the notice and consent process as described in the Consolidated Appropriations Act of 2021 Notice in the **Health Benefits Coverage Under Federal Law** section. Your cost-shares will be based on the Recognized Amount, and will be applied to Your Network Deductible and network out-of-pocket Limit.

Treatment You get after Your condition has stabilized is not Emergency Care. Please refer to the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section for more details on how this will impact Your benefits.

The Maximum Allowed Amount will be used to determine payment for Emergency Care from an Out-of-Network Provider. However, Member cost-share will be based on the median Plan Network contract rate paid to Network Providers for the geographic area where the service is provided for the same or similar service.

The Coinsurance percentage payable for both network and out-of-network are shown in the **Schedule of Benefits**.

Gender-Affirming Surgery and Services

This Plan provides benefits for many of the charges for gender-affirming surgery and services for Members diagnosed with Gender Dysphoria. Gender-affirming surgery and services must be approved by us for the type of procedure requested and must be authorized prior to being performed. Charges for services that are not authorized for the gender-affirming surgery and services requested will not be considered Covered Services. All services must be authorized by us as outlined in the **Healthcare/Medical Management - Precertification** section. Please refer to the **Schedule of Benefits** section for details pertaining to Copayment and/or Coinsurance.

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 healthcare 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 impairment in a variety of Inpatient and/or outpatient settings.

Home Healthcare Services

Home Healthcare 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. The Physician's statement and recommended program may require Precertification. Please refer to the **Healthcare/Medical Management-Precertification** section for details.

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.

Covered Services for Home Healthcare do not include:

- Food, housing, homemaker services, sitters, home-delivered meals;
- Home Healthcare 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 Healthcare 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;
- Hemodialysis 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, records, tapes 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
Your Plan includes coverage for Medically Necessary human organ and tissue transplants.

Covered Procedures
Covered procedures as approved by the Claims Administrator include:

- Any Medically Necessary human solid organ, tissue, and stem cell/bone marrow transplants and infusions; and
- Any Medically Necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

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 that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as a network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is a Network Provider for other services, it may not be a network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are network Transplant Providers.

Centers of Medical Excellence (CME) Transplant Providers
Blue Distinction Center Facility: Blue Distinction Facilities have met or exceeded national quality standards for care delivery.

Centers of Medical Excellence (CME): Centers of Medical Excellence Facilities have met or exceeded quality standards for care delivery.

Network Transplant Provider: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. The Provider has entered into a Transplant Provider agreement to give Covered Transplant Procedures to You and take care of certain administrative duties for the Transplant Network. A Provider may be a Network Transplant Provider for certain Covered Transplant Procedures or all Covered Transplant Procedures.

Out-of-Network (PAR) Transplant Provider: Providers participating in the Plan's Networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.

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 Solid Organ Transplant Procedure and one day before high-dose chemotherapy or preparative regimen for a Covered Bone Marrow/Stem Cell Transplant Procedure and lasts for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the 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 the day of 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. Your Provider must certify, and the Claims Administrator must agree that the covered procedure is Medically Necessary. Not getting Precertification will result in a denial of benefits.

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**. Any limits for speech therapy will not apply if You receive care with the primary diagnosis of Mental Health and/or Substance Use Disorder as described on the claim form. Limits and cost-shares for speech therapy will process according to the Mental Health and Substance Use Disorder benefit. 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. (Please refer to "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 Healthcare 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 permitted under Indiana law if, for reasons based upon the professional, medical judgment of the pregnant woman's physician:

(i) the abortion is necessary when reasonable medical judgment dictates that performing the abortion is necessary to prevent any serious health risk to the pregnant woman or to save the pregnant woman's life;
(ii) the fetus is diagnosed with a lethal fetal anomaly; or
(iii) the pregnancy is a result of "rape or incest" (as defined by SEA 1 – 2022 Special Session, IC 16-18-2-306.7).

Infertility Services

Your Plan also includes benefits for the diagnosis of Infertility. Please refer to the **Schedule of Benefits** for benefit limitations and Coinsurance amounts.

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

Medical Care

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

Mental Healthcare and Substance Use Disorder Treatment

Please refer to the **Schedule of Benefits** for any applicable Deductible and Coinsurance information. Coverage for the diagnosis and treatment of Mental Healthcare and Substance Use Disorder on an Inpatient or outpatient basis will not be subject to Deductibles or Coinsurance provisions that are less favorable than the Deductibles 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 and therapy.

- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs and Intensive In-Home Mental Health Programs.
- **Medication-Assisted Treatment** Drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for Substance Use Disorders, including opioid use disorder
- **Virtual Visits**- Please refer to Virtual Visits in this section.

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.

Nutritional Counseling
Nutritional counseling related to the medical management of a disease state as stated in the **Schedule of Benefits**. Any limits for nutritional counseling will not apply if You receive care with the primary diagnosis of Mental Health and/or Substance Use Disorder as described on the claim form. Limits and cost-shares for nutritional counseling will process according to the Mental Health and Substance Use Disorder benefit.

Out-of-Network Freestanding Ambulatory Surgery Center
Any services rendered or supplies provided while You are a patient or receiving services at or from an out-of-network Freestanding Ambulatory Surgery Center 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.

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.

Online Visits
Please refer to Virtual Visits in this section.

Oral Surgery
Covered Services include only the following:
- Fracture of facial bones;
- 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 myofascial pain, including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include 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 (e.g. removal of wisdom teeth) 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.

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 Surgery Center charges are covered at regular Plan benefits. Benefits for treatment by an out-of-network Hospital are explained under "Hospital Services".

Pediatric Neuropsychiatric Disorders

This Plan provides coverage for treatment of Pediatric Neuropsychiatric Disorders for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS). and pediatric acute-onset neuropsychiatric syndrome (PANS) including treatment with intravenous immunoglobulin therapy. Coverage will not be subject to dollar limits, Deductibles, Copayment or Coinsurance that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to other coverage under Your Plan.

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. Any limits for physical and occupational therapy will not apply if You receive care with the primary diagnosis of Mental Health and/or Substance Use Disorder. Limits and cost-shares for physical therapy and occupational therapy will process according to the Mental Health and Substance Use Disorder benefit.

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 care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA). This means many preventive care services are covered with no Deductible 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* - Including mammograms and additional imaging to complete the screening process (e.g., magnetic resonance imaging (MRI), ultrasound, mammography), and pathology / biopsy evaluation as recommended by the Health Resources and Services Administration.
   b. Cervical cancer*.
   *Includes patient navigation services
   c. Colorectal cancer, including the preventive colonoscopy, anesthesia, polyp removal, and pathology tests in connection with the preventive screening. It also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test, i.e., flexible sigmoidoscopy and CT colonography.
   d. High blood pressure.
   e. Type 2 diabetes mellitus.
   f. Cholesterol.
   g. Child and adult obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention or considered Medically Necessary, according to Anthem's medical policy.

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, as covered under Your medical benefits, sterilization procedures, and counseling. Coverage only includes contraceptive devices, such as diaphragms, intrauterine devices (IUDs), and implants.

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

   c. Gestational diabetes screening.

5. Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:

a. Counseling.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by Your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests.

You may call Member Services using the number on Your Identification Card or visit our website at www.anthem.com 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 https://www.cdc.gov/acip/vaccine-recommendations/index.html.)

Preventive Care for Chronic Conditions (per IRS guidelines)

Members with certain chronic health conditions may be able to receive preventive care for those conditions prior to meeting their Deductible, when services are provided by a Network Provider.

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

Prosthetics

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

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

- Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes).
- Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act. This includes coverage for custom fabricated breast prostheses and one (1) additional breast prosthesis per breast affected by the 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.

Note: Coverage for reconstructive services does not apply to orthognathic surgery. Please refer to 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.
- 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.

Virtual Visits

When available in Your area, Your coverage will include Virtual Visits. Covered Services include virtual Telemedicine/Telehealth visits, appropriately provided through the internet via video. This includes visits with Providers who offer services in person in addition to virtual visits conducted through our mobile app or at www.anthem.com. Please refer to "Physician Services" in the **Schedule of Benefits** section for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information. For Mental Health and Substance Use Disorder Virtual Visits, please refer to "Mental Healthcare and Substance Use Disorder" in the **Schedule of Benefits** section.

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

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
- Physician-to-Physician consultation

Prescription Drug Benefits

Managing Specialty Medications

If You are utilizing a Specialty Drug, our goal is to provide You with access to the most clinically appropriate therapy to meet Your treatment needs. These Drugs are used to treat complicated and chronic conditions, such as cancer, rheumatoid arthritis, multiple sclerosis, and other diseases. Health issues like these can be challenging to manage and we want to assure that You receive safe, effective treatment.

Providing coverage under the best benefit (Pharmacy or medical) is the first step. Specialty medications which You can give to Yourself are best managed under the Pharmacy benefit. Drugs which require a medical professional to give to You will be provided under Your medical benefit.

Anthem also requires Precertification for certain Specialty Drugs under the medical benefit. This means that a clinical review is required before the Drug is approved. Precertification assures consistent use of effective medications based on our clinical criteria and treatment guidelines. We also review for correct dose and frequency as well. During this time, our pharmacists will work with Your Physician to incorporate additional dose reduction opportunities that are still clinically appropriate for You. Your Physician will contact us for Precertification and provide us with the clinical information needed for us to review the request.

Our final focus is on the setting in which Your treatment may occur. There are multiple options available to You typically selected by Your Physician. Did You know that the outpatient Hospital setting can be 2-3 times more costly than other sites? Receiving care in a lower cost site which can meet Your specific needs can help You and Your Employer save money and can also possibly provide You with more convenient options in which to receive Your Drug treatment. The Site of Care program requires that Your prescriber provide information on the level of care that You need. You may be redirected to receive Your care in Your Physician's office, an infusion center, or from a home infusion Provider instead of the outpatient Hospital.

All of these approaches work cohesively together to help You with Your medical Specialty Drug needs.

Prescription Drugs Administered by a Medical Provider

This Plan covers Prescription Drugs including Specialty Drugs, that must be administered to You as part of a doctor's visit, Home Healthcare visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to You in a medical setting. Benefits for Drugs that You inject or get through Your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section.

Covered Prescription Drugs

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

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

What's Not Covered

1. 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.

2. Drugs not approved by the FDA.

Precertification

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

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

Please refer to the section **Healthcare/Medical Management - Precertification** for more details.

If Precertification is denied, You have the right to file an appeal as outlined in the **Your Right To Appeal** section of this Benefit Booklet.

Designated Pharmacy Provider

The Plan in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific Pharmacy services (including shipment of Prescription Drugs) to Members. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with the Claims Administrator. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

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

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

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the out-of-network level.

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

Therapeutic Equivalents

Therapeutic equivalents is a program that tells You and Your Providers about alternatives to certain prescribed Drugs. The Claims Administrator may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic equivalent is right for You. For questions or issues about therapeutic Drug equivalents , call Member Services at the phone number on the back of Your Identification Card.

LIMITATIONS AND EXCLUSIONS

The following section indicates items which are excluded and are not Covered Services. Unless otherwise stated in this Plan's Benefits' Article, no benefits are provided for care and supplies related to:

- Human organ or tissue transplants other than as specifically stated as covered in the Benefits' Article.
- Artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
- Artificial insemination.
- In vitro fertilization.
- Gamete intra fallopian transfer (GIFT).
- Immunizations except as specifically stated.
- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- Reversal of sterilization.
- Services or supplies prescribed, ordered or referred by or received from a member of Your immediate family, including Your spouse, child, brother, sister, parent, in-law, or self.
- Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
- Hearing aids or examinations for prescribing or fitting them.
- Services, supplies, or charges which the Plan determines are not Medically Necessary or do not meet the Plan's medical policy, clinical coverage guidelines, or benefit policy guidelines.
- Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional. This includes services at residential treatment Facility. Residential treatment means individualized and intensive treatment in a residential Facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. However, mental health and substance abuse residential treatment is a covered benefit.
- Dental treatment, regardless of origin or cause, except as specified elsewhere in this Plan's Benefits' Article. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service as stated in this Plan's Benefits' Article) or gums, including but not limited to: extraction, restoration and replacement of teeth. Medical or surgical treatments of dental conditions. and Services to improve dental clinical outcomes.
- Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- Dental Implants.
- Dental braces.
- Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
    1. transplant preparation;
    2. initiation of immunosuppresives.; or
    3. direct treatment of acute traumatic injury, cancer or cleft palate.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
- Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility. Private Duty Nursing Services are Covered Services only when provided through the Home healthcare Services benefit as specifically stated in this Plan's Benefits' Article.

- Routine foot care (including the cutting or removal of corns and calluses). Nail trimming, cutting or debriding. Hygienic and preventive maintenance foot care, including but not limited to:
    1. cleaning and soaking the feet.;
    2. applying skin creams in order to maintain skin tone.; or
    3. other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- Surgical treatment of flat feet. subluxation of the foot. weak, strained, unstable feet. tarsalgia. metatarsalgia. hyperkeratoses.
- Any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.
- Examinations relating to research screenings.
- Developmental delays except for Pervasive Developmental Disorders (including Asperger's syndrome and autism) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, learning impairment, hyperkinetic syndromes, or mental retardation.
- Illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
- Services and supplies for which You have no legal obligation to pay in the absence of this or like coverage.
- Services and supplies incurred prior to Your Effective Date.
- Services and supplies incurred after the termination date of this coverage except as specified elsewhere.
- Services or supplies provided by a sanitarium, or rest cures.
- Services or supplies furnished by any person or institution acting beyond the scope of her/his/its license.
- Plan benefits to the extent that the services are a Medicare Part A or Part B liability.
- Services and supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Services and supplies to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- Mileage, lodging and meals costs, and other Covered Person's travel related expenses, except as authorized by the Plan or specifically stated as a Covered Service. Services or supplies if the Plan does not state that benefits are provided for them.
- Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by the Plan.
- Missed or canceled appointments.
- Completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Recreation or diversional therapy.
- The cost of materials used in any Occupational Therapy.
- Personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment. personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals. charges for failure to keep a scheduled visit. for non-medical self-care except as otherwise stated. purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program. for a health spa or similar Facility.

- Hospitalization for environmental change or Provider charges connected with prescribing an environmental change.
- Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in this Plan's Benefits' Article. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity as required by law are covered. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
- Stand-by charges of a Physician.
- Male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or Implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
- Drugs in quantities which exceed the limits established by the Plan.
- Prescription Drugs, except as provided through the Pharmacy Benefits Manager.
- The Prescription Drug Copayment portion of the Pharmacy Benefits Manager.
- Any medications dispensed in a physician's office.
- 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.
- Diagnostic testing or treatment related to infertility.
- Marital counseling.
- Services and supplies received from an individual or entity that is not a Provider, as defined in this Plan's Benefits' Article, or recognized by the Plan.
- A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- Services which are performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
- Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- Expenses incurred at a health spa or similar Facility.
- Self-help training and other forms of non-medical self care, except as otherwise provided herein.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, or for licensing.
- Experimental/Investigative Services:
  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 Plan determines to be Experimental/Investigative is not covered under the Plan. The Plan will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if it 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:
  1. 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.;
  2. has been determined by the FDA to be contraindicated for the specific use; or
  3. 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
  4. is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

5. 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 Plan. In determining whether a Service is Experimental/Investigative, the Plan will consider the information described below and assess whether:

1. the scientific evidence is conclusory concerning the effect of the service on health outcomes;
2. 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;
3. 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
4. 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 Plan 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:

1. published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
2. evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
3. 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
4. documents of an IRB or other similar body performing substantially the same function; or
5. 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
6. medical records; or
7. the opinions of consulting Providers and other experts in the field.

The Plan 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.

- Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- Court ordered testing or care unless Medically Necessary.
- Charges in excess of the Maximum Allowed Amount.
- Procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical

functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law. Complications directly related to cosmetic services treatment or surgery are not covered

- Vision orthoptic training. This Exclusion does not apply to Medically Necessary therapy to treat amblyopia.
- Care received in an emergency room which is not Emergency Care, except as specified as covered.
- Chiropractic services rendered in the home as part of Home healthcare Services.
- Alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.
- Hiring, or the services of, a surrogate mother.
- Surgical treatment of gynecomastia.
- Any service for which a Covered Person is responsible under the terms of this Plan to pay a Copayment or Coinsurance and the Copayment or Coinsurance is waived by a non-Network Provider.
- 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.
- Elective abortions.
- Diabetic test/strips and lancets are limited to Prescription Drug coverage (excluded on medical). however, other diabetic supplies will be covered under medical.
- Services from a Provider that does not meet the definition of Facility.
- 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.
- Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator except for Surprise Billing Claims as outlined in the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law**.
- Non-Approved Facility - Services from a Provider at a Facility that does not meet the definition of Facility.

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 15 months after the service was provided. This section of the Benefit Booklet describes when to file 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 healthcare provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the Provider.

For healthcare 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 refer to 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 our 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. Except for Surprise Billing Claims*, 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.

*Surprise Billing Claims are described in the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law**. Please refer to that section for further details.

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the 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 reimbursement policies, and/or reimbursement requirements. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same 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 Medical 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 adjusted or unadjusted for geographic locality, no less than annually; or

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

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

5. An amount based on the Qualifying Payment Amount, which is generally the median contracted rate for the same or similar Provider for the same or similar service in the geographic service area; or

6. 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 us 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 unless Your claim involves a Surprise Billing Claim. 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.

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 refer to 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.

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, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider (this is referred to as "In-For-Out Benefit Treatment"). In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Service in order to get approval for In-For-Out Benefit Treatment. If the Plan authorizes a network cost-share amount for Non-Emergency Care for Covered Services provided by an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless Your claim involves a Surprise Billing Claim. Please contact Member Services for Authorized Services information or to request authorization.

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 15 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.

Notice of Claim & Proof of Loss

After You get Covered Services, we must receive written notice of Your claim within 15 months in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless otherwise required by law (e.g., Federal law allows exceptions for claims filed by the Veteran's Administration up to a maximum 6 years from the date of service).

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, 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 information regarding the right to bring an action after the appeals process.

Inter-Plan Programs

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 Programs." These Inter-Plan Programs 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 Programs. The Inter-Plan Programs 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 pay both kinds of Providers are paid.

Inter-Plan Programs Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Programs, 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 (please 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 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 **Healthcare/Medical 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 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., except for claims for Emergency Care or Surprise Billing Claims for air Ambulance Services or non-Emergency Services performed by Out-of-Network Providers at certain network Facilities, which will be paid directly to Providers and Facilities. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or You) will discharge the 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 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 Identification Card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of Your complaint, You have the right to file an appeal, which is defined as follows:

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

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

If Your claim is denied or if Your coverage is rescinded:
- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable Federal regulations.

Notice of Adverse Benefit Determination
If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:
- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action within one year of the grievance or appeal decision if You submit a grievance or appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- information regarding Your potential right to an External Appeal pursuant to Federal law.

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify You or Your authorized representative within 72 hours orally and then furnish a written notification.

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

The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The timeframe allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

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

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

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

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

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

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

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

The Claims Administrator will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an adverse benefit determination or review based on a new or additional rationale, the Claims Administrator will provide You, free of charge, with the rationale.

How Your Appeal will be Decided
When the Claims Administrator considers Your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

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

Notification of the Outcome of the Appeal
If You appeal a claim involving urgent/concurrent care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.

If You appeal any other pre-service claim, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

If You appeal a post-service claim, the Claims Administrator will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

Appeal Denial
If Your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled “Notice of Adverse Benefit Determination.”

If, after the Plan’s denial, 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 decision 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 the Claims Administrator’s control.

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

External Review
If the outcome of the mandatory first level appeal is adverse to You and it was based on medical judgment, or if it pertained to a rescission of coverage, You may be eligible for an independent External Review pursuant to Federal law.

You must submit Your request for External Review to the Claims Administrator within four (4) months of the notice of Your final internal adverse determination.

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

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

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

For Surprise Billing Claims, if Your claim for the date of service starting 01/01/2022 and after is not paid in full and is related to Emergency Services or Air Ambulance Services from an Out-of-Network Provider, or Covered Services from an Out-of-Network Provider at a Network Facility, and You believe the Claims Administrator priced those claims as out-of-network Benefits, You have the right to request an external review by an Independent Review Organization. If eligible for an independent external review, there is no cost to You. You have four months from the date You receive this letter to ask for an independent external review. Your request must be in writing to the address noted in this section.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by You or Your authorized representative to:

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348

You must include Your Member identification number when submitting an appeal.

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

Requirement to file an Appeal before filing a lawsuit
No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's decision on the claim or other request for benefits from which the appeal was taken shall be considered the Plan's final decision, and the one-year period in which a lawsuit or legal action must be brought shall run from the date of that final decision, not the date on which Anthem decided the appeal was untimely. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when You have healthcare 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 and/or Deductible 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 Medicare, 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 healthcare 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 healthcare 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 healthcare 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 healthcare expense, including Deductibles and/or Coinsurance, 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.

Closed panel Plan is a Plan that provides healthcare 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 healthcare expenses or healthcare 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 healthcare expenses or healthcare 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 healthcare expenses or healthcare 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 healthcare expenses or healthcare 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.

Secondary to Other Coverage

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

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

Definitions

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

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

Subrogation

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

Reimbursement

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

Secondary to Other Coverage

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

Assignment

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

Applicability to All Settlements and Judgments

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

Constructive Trust

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

Lien Rights

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

First-Priority Claim

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

Cooperation

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

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

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

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

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

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

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

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

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

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

Discretion

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

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

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

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. If 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 requires us to be the primary payer, the benefits under this Plan do not duplicate any benefit for which Members are entitled to or eligible under Medicare, including Parts A and/or B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to You shall be reimbursed by or on Your behalf to us, to the extent we have made payment for such services. When a member or a provider opts out of Medicare Parts A and/or B we will process the claim as if Medicare made a payment. Please refer to Medicare.gov for more details on when Medicare is primary (i.e., who pays first) and when you should enroll.
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Member Rights and Responsibilities

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

This statement can be found on our website. To access, go to www.anthem.com and select “Member Support.” Under the Support column, select “FAQs” and Your state, then the “Laws and Rights That Protect You” category. Click on the “What are my rights as a member?” question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member’s Identification Card.

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.

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 a 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.

Anthem Insurance Companies, Inc. 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 Insurance Companies, Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks. 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. 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.

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, Procedures, and Pilot Programs

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, case management, clinical quality, 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. The Claim's 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 Healthcare 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.

Not Liable for Provider Acts or Omissions

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

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 healthcare 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 healthcare. 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 healthcare 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 Plan may also offer with discretion the ability for You to participate in certain voluntary health or condition-focused digital applications, or use other technology-based interactive tools, or receive educational information to help You stay engaged and motivated, manage Your health, and assist in Your overall health and well-being. The purpose of these programs and incentives includes, 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 a program or an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, 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 a disabled child over age 26 ceases if the child is found to be no longer totally or permanently disabled.

Coverage of the Spouse of a Subscriber terminates automatically as of the date of divorce or death.

Should You or any family Members be receiving covered care in the Hospital at the time Your membership terminates for reasons other than Your Employer's cancellation of this Plan, or failure to pay the required premiums, benefits for Hospital Inpatient care will be provided until the date You are discharged from the Hospital.

Continuation of Coverage (Federal Law-COBRA) if applicable

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
For Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
For Spouses/ Dependents: A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of	18 months

Qualifying Event	Length of Availability of Coverage
Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	
Covered Employee's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Employee	36 months
For Dependents: 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 disabled 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 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 healthcare benefits that would have been provided if the Employee were working, with the same premium contribution ratio.

If membership in the Plan is discontinued for non-payment of premium, the Employee's coverage will be restored upon return to work 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 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 healthcare 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.

Ancillary Services
Ancillary Services are supportive or diagnostic measures that supplement and support primary healthcare Providers in treating patients. Examples of Ancillary Services include, but are not limited to, Emergency Services, anesthesiology, laboratory and pathology services, radiology, neonatology, Diagnostic Services, and assistant surgeons.

Authorized Service(s)
A Covered Services rendered by any Out-of-Network Provider, which has been authorized in advance (except for Emergency Care) by the Claims Administrator will 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, Copayment, or Deductible unless Your claim is a Surprise Billing Claim. For more information, please refer to the **Claims Payment** section as well as the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section.

Benefit Booklet
This document, referred to as a Benefit Booklet, describes the terms of Your benefits, including any cost-shares in which You may be accountable. It is part of the Plan offered by Your Employer.

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.

Centers of Medical Excellence (CME) Network
A Network of healthcare 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 healthcare 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. Please refer to the **Schedule of Benefits** for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment.

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.

Consolidated Appropriations Act of 2021
Please refer to the **Consolidated Appropriations Act of 2021** in the **Health Benefits Coverage Under Federal Law** section for details.

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 healthcare 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. It usually is applied on a calendar year basis.

Dependent
The Spouse and all children until attaining age limit as shown in the **Eligibility** section of this Benefit Booklet. 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 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.

Designated Pharmacy Provider
A network Pharmacy that has executed a Designated Pharmacy Provider Agreement with the Claims Administrator or a Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs.

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.

Diagnostic Service(s)
Any claim for services performed to diagnose an illness or Injury, which may include, but is not limited to, ultrasounds, X-rays, and MRIs. Please refer to the **Schedule of Benefits** for more details about Your benefit coverage.

Durable Medical Equipment
Equipment which is (a) made to withstand prolonged use. (b) made for and mainly used in the treatment of a disease of 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 Medical Condition
("Emergency Services," "Emergency Care," or "Medical Emergency") Emergency Medical Condition means a medical or Mental Health and Substance Use Disorder 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:

- 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;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Medical Services Provider Organization
A provider of Emergency medical services that is certified by the Indiana emergency medical services commission as an advanced life support provider organization under Indiana law.

Employee
A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer
An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The

Employer or other organization has an Administrative Services Agreement with the Claims Administrator to administer this Plan.

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 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 Surgery Center, Residential Treatment Center, or Skilled Nursing Facility as defined in this Benefit Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

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 Surgical Center
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 (RNs). It must be licensed as required by law, meet our accreditation requirements, and be approved by us. A Physician's office does not qualify as a Freestanding Ambulatory Surgery Center.

Gender Dysphoria
The distress a person feels due to a mismatch between their gender identity: their personal sense of their own gender and their gender assigned at birth.

Group Health Plan or Plan
An employee welfare benefit Plan, established by the Employer, in effect as of the Effective Date.

Home Healthcare
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 Healthcare 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 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 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 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
A Facility licensed as a Hospital as required by law that must satisfy our accreditation requirements and is approved by us. The term Hospital 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, and subacute care.

Hospitalist
A dedicated in-patient Physician who works exclusively in a hospital, providing healthcare services within the scope of an applicable license, satisfies the Claims Administrator's accreditation requirements, and for Network Providers is approved by the Claims Administrator.

Identification Card (ID 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.

In-For-Out Benefit Treatment
A Covered Service rendered by an Out-of-Network Provider, authorized in advance by the Claims Administrator to be paid at the network level. This is also referred to as Out-of-Network Referrals.

Ineligible Charges
Charges for healthcare 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. This does not include conditions such as when the cause is a vasectomy, orchiectomy, 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 Mental Health Programs
A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a Mental Health or Substance Use Disorder, put the Members and others at risk of harm.

Intensive Outpatient Programs
Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group, and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Intensivist
A board-certified Physician who provides special care for critically ill patients within the scope of an applicable license, satisfies the Claims Administrator's accreditation requirements, and for Network Providers is approved by the Claims Administrator.

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, please refer to 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.

Mental Healthcare/Mental Health and Substance Use Disorder
Includes services for mental health and substance use disorder. Mental health and substance use disorder 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 use disorder condition.

Network Provider (In-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 refer to "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 Surgery Center, Physician, Skilled Nursing Facility, Hospice, Home Healthcare 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-Network Referrals
A Covered Service rendered by an Out-of-Network Provider, authorized in advance by the Claims Administrator to be paid at the Network level. This is also referred to as In-For-Out Benefit Treatment.

Out-of-Pocket Maximum
The maximum amount of a Member's Coinsurance payments during a given calendar 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 treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group, and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Pharmacy
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.

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

Physician
Any licensed Physician of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Physician 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 Physician of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Physician 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, which could be the Employer or a union, 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)
A substance under the Federal Food, Drug & Cosmetic Act, that 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, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a Drug manufacturer. and
- insulin.

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/Precertification/Preauthorization
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 professional or Facility licensed when required by law that provides healthcare services within the scope of an applicable license, must satisfy our accreditation requirements, and be approved by us. Details on our accreditation requirements can be found at https://www.anthem.com/provider/individual-commercial/join-our-network This includes any Provider that state law says must be covered under this Plan when they give You Covered Services. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question about a Provider not described in this Benefit Booklet, please call the number on the back of Your Identification Card.

A Provider Network is a list of doctors, other healthcare Providers, Facilities, and Hospitals that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members. These Providers are known as “Network Providers” throughout this Benefit Booklet. A Provider that isn’t contracted with the Claims Administrator is called an “Out-of-Network Provider.” Please refer to the definitions of a Network Provider and Out-of-Network Provider in this section for more information.

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.

Qualifying Payment Amount
The median Plan network contract rate the Claims Administrator pays Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount
For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For air Ambulance Services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan network contract rate the Claims Administrator pays Network Providers for the geographic area where the service is provided

for the same or similar services) or the amount billed by the out-of-network air Ambulance Service Provider.

For all other Surprise Billing Claims, the Recognized Amount is the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network Provider or Out-of-Network Facility; or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Residential Treatment Center/Facility

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorder conditions. The Facility must be licensed as a Residential Treatment Center in the state in which it is located, must satisfy our accreditation requirements, and be approved by us.

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

- 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. The State of Indiana has a clinic onsite at Indiana Government Center South.

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 Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a Skilled Nursing Facility in the state in which it is located, satisfy our accreditation requirements, and be approved by us. A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care, or domiciliary care, or a place for rest, educational, or similar services.

Specialist (Specialty Care Physician\Provider or SCP)

A Specialist is a Physician 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 healthcare.

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.

Subscriber
An Employee of the Employer who is eligible for and has enrolled in the Plan.

Surprise Billing Claim
Please refer to the **Consolidated Appropriations Act of 2021 Notice** in the **Health Benefits Coverage Under Federal Law** section for details.

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

Telehealth (Telemedicine)
The delivery of healthcare or other health services using electronic communications and information technology, including, but not limited to, live (synchronous) secure videoconferencing or secure instant messaging or remote patient monitoring technology. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or Mental Health. In-person contact between a healthcare Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

Transplant Providers

Network Transplant Provider - A Provider that has been designated as a "Center of Medical 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 Medical Excellence" for Transplants by the Claims Administrator or 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 Mental Health services, Prescription Drugs (as set forth in the section "Prescription Drugs Administered by a Medical Provider"), procedures, and/or Facilities.

Virtual Visits
Virtual Visits are also known as Online Visits, Telehealth, and Telemedicine. These visits are a method of consulting with Your Physician (PCP/Specialist) using visual and/or audio devices (Computer, Smart Phone, Tablet). Please refer to the Virtual Visits description in the **Benefits** section or the Physician Services coverage information in the **Schedule of Benefits** section.

You and Your
Please 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 please 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 healthcare professional in the Claims Administrator's Network who specializes in obstetrics or gynecology. The healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or please 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. Please refer to 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 quantitative treatment limitations (day or visit limits) on Mental Health and Substance Use Disorder benefits with day/visit limits on medical/surgical benefits. In general, Group Health Plans offering Mental Health and Substance Use Disorder benefits cannot set day/visit limits on Mental Health or Substance Use Disorder benefits that are more restrictive than the predominant limit applicable to substantially all of the day/visit limits for medical and surgical benefits within a benefit classification (e.g., Inpatient, outpatient, Emergency Service, etc.). 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 Use Disorder benefits offered under the Plan within the same benefit classification. Also, the Plan may not impose Deductibles, Copayment/Coinsurance, and out-of-pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than the predominant Deductibles, Copayment/Coinsurance, and out-of-pocket expenses applicable to substantially all medical and surgical benefits in the same classification. Medical Necessity criteria are available upon request. Please refer to the **Schedule of Benefits** section in this Benefit Booklet for specific details.

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 30 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 30 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.

Consolidated Appropriations Act of 2021 (CAA)

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

Surprise Billing Claims

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

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

No Surprises Act Requirements

Emergency Services

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

- Without the need for Precertification;
- Whether the Provider is network or out-of-network;

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

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

Out-of-Network Services Provided at a Network Facility

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

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

- By obtaining Your written consent not later than 72 hours prior to the delivery of services; or

- If the notice and consent is given on the date of the service, if You make an appointment within 72 hours of the services being delivered.

Post-stabilization

Post-stabilization consists of a four-part test:

1. The attending Physician determines that the Member is able to travel using nonmedical transportation to a Network Provider or Facility within a reasonable distance, taking into consideration the Member's medical condition;
2. The Network Provider/Facility satisfies notice and consent criteria;
3. The Member or their authorized representative must be in the condition to provide informed and voluntary consent; and
4. The Network Provider/Facility must satisfy any additional state law requirements.

Out-of-Network Air Ambulance Services

When You receive Covered Services from an out-of-network air Ambulance Provider, Your out-of-pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by a network air ambulance Provider.

How Cost-Shares Are Calculated

Your cost-shares for Surprise Billing Claims will be calculated based on the Recognized Amount. Any Out-of-Pocket cost-shares You pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at a network Facility or for Covered Services provided by an Out-of-Network air Ambulance Service Provider will be applied to Your network out-of-pocket Limit.

Appeals

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

Provider Directories

Anthem is required to confirm the list of Network Providers in its Provider directory every 90 days. If You can show that You received inaccurate information from Anthem that a Provider was listed as in network on a particular claim, then You will only be liable for network cost-shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your Network cost-shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

Anthem provides at its website, anthem.com, protections with respect to Surprise Billing Claims by Providers, including information on how to contact state and Federal agencies if You believe a Provider has violated the No Surprises Act. You can find this information directly at https://www.anthem.com/no-surprise-billing/

You may also obtain the following information on Anthem's website or by calling Member Services at the phone number on the back of Your Identification Card:

- Cost sharing information for covered items, services, and Drugs as required by the Centers for Medicare & Medicaid Services (CMS); and

- A listing / directory of all Network Providers.

In addition, Anthem will provide access through its website to the following information:
- Network negotiated rates; and
- Historical out-of-network rates.

Notice Regarding Retiree-Only Plans

If this Plan is issued as part of a retiree-only Plan, as defined by ERISA §732(a) and IRC §9831(a)(2), the provisions of the Consolidated Appropriations Act of 2021 will not apply, including the provisions regarding the No Surprises Act. In a retiree-only Plan, Out-of-Network Providers may bill You for any charges that exceed the Plan's Maximum Allowed Amount. Please contact your Employer or former Employer if You are unsure whether Your Plan is a retiree-only Plan.

Indiana Surprise Billing Law Notice

If you receive non-Emergency Care from an Out-of-Network professional Provider at an In-Network Facility, your cost-shares will be calculated using the Plan's Maximum Allowed Amount. Out-of-Network professional Providers may bill you for any difference between the Maximum Allowed Amount and the Out-of-Network professional Providers' billed charges only if the Our-of-Network professional Provider gives you proper notice of its charges not later than 5 business days prior to the delivery of scheduled services, and obtains your signed written consent to the charges This section of the Indiana Surprise Billing law notice controls whenever there is a conflict with the Consolidated Appropriations Act of 2021 notice above. For purposes of the "Indiana Surprise Billing law" an "Out-of-Network professional provider" includes any individual licensed by a board in Indiana Code 25-0.5-11-1, except for a dentist, optometrist, or provider facility.

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 Corporation (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 impairment. For people with impairments, 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, impairment, 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, 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 https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.

WE'RE HERE FOR YOU – IN MANY LANGUAGES

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma
sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？
您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của
tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가
있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로
전화하십시오. 시각 장애인이신가요? 다른 형식으로
된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga
format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи
на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы
со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու
ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի
վրա գտնվող Անդամների սպասարկման համարին:
Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև
խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua
lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di
questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache
zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen
Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht’s Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei
ID Card. Hoscht Druwwel fer sehne? Du kannscht des
do Schreiwes in en differnter Weg griege so as du’s
besser sehne kannscht.

TTY/TTD:711

It’s important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don’t discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn’t English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed
in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator,
P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf