Certificate of Coverage

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

Anthem Student Health Plan

Wright State University

07-01-2023

Anthem Student Advantage OH SHP Blue Access Plan

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

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

Community Insurance Company

4361 Irwin Simpson Road
Mason, Ohio 45040

This Benefit Booklet is not a Medicare supplement (policy or certificate). If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from us.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

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

Surprise Billing Claims

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

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

No Surprises Act Requirements

Emergency Services

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

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

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

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

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

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

services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

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

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

Out-of-Network Air Ambulance Services

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

How Cost-Shares Are Calculated

Your cost shares for Surprise Billing Claims will be calculated based on the "Recognized Amount." The Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance Service Provider.
- For all other Surprise Billing Claims, except where otherwise required by law the Recognized Amount is the lesser of the amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act, the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services), or the amount billed by the Out-of-Network Provider or Out-of-Network Facility

Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility or for Covered Services provided by an Out-of-Network Air Ambulance Service Provider will be applied to your In-Network Out-of-Pocket Limit.

Appeals

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

Provider Directories

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

Transparency Requirements

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

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

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

- Cost sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A list of all In-Network Providers.

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

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

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We generally allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our 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 Precertification from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Precertification for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

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

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

Mental Health Parity and Addiction Equity Act

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

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the school stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the school stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

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

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

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

Introduction

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

The Booklet explains many of the rights and duties between you and us. It also describes how to get health care, what services are covered, and what part of the costs you will need to pay. Many parts of this Booklet are related. Therefore, reading just one or two sections may not give you a full understanding of your coverage. You should read the whole Booklet to know the terms of your coverage.

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

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Contract issued to your University, and the Plan that your University chose for you. The Contract, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available.

Many words used in the Booklet have special meanings (e.g., University, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. Please see these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Community Insurance Company dba Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Student and each covered Dependent.

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

Student Health Center (SHC) and/or University Health Service (UHS)

The University may offer a separate program which allows you to receive services through a Student Health Center (SHC) or through other providers of University Health Services (UHS). Check with your University to learn more. If the University offers such a program, the Student and Spouse/Dependent should use the services the Student Health Center (SHC) and/or University Health Services (UHS) first where outpatient/physician treatment will be administered or any required referral issued.

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. 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 help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

President

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AMENDMENT

This Amendment revises the Health Certificate of Coverage as described below. It supersedes any provision in the Certificate with which it may be in conflict.

The following is added:

Student Health Center (SHC) Referral Required – Students Only

The Student should use the services of the SHC first where treatment will be administered or referral issued. Expenses incurred for medical treatment rendered outside of the SHC for which no prior approval or referral is obtained will be subject to an additional $350 Deductible. A referral issued by the SHC must accompany the claim when submitted. Only one referral is required for each illness or injury per Benefit Period.

A SHC referral for outside care is not necessary only under any of the following conditions:

1. Medical Emergency. The Student must return to the SHC for necessary follow-up care.
2. When the SHC is closed.
3. When service is rendered at another Facility during break or vacation period.
4. Medical care received when the Student is more than 50 miles from campus.
5. Medical care obtained when a Student is no longer able to use the SHC due to a change in Student status.
6. Maternity, obstetrical and gynecological care.
7. Mental Health and Substance Abuse treatment.

Dependents are not eligible to use the SHC; and therefore, are exempt from the above limitations and requirements.

Jane Peterson

President

AMENDMENT

Community Insurance Company
4361 Irwin Simpson Road
Mason, Ohio 45040

Effective Date: 08/01/2023

This Amendment revises your Health Certificate of Coverage as described below. It supersedes any provision in the Certificate with which it may be in conflict.

In the "Schedule of Benefits" section, under "Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits", the following benefit has been added to your Plan:

Specialty Drug Copayments / Coinsurance

Please note that Anthem may increase the cost shares listed above in order to take full advantage of cost share assistance that is available from drug manufacturers. This will lower plan costs but will not increase your cost because any additional cost share will be offset by Cost Relief.

In the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section, under "Additional Features of Your Prescription Drug Pharmacy Benefit", the following benefit has been added to your Plan:

Drug Cost Share Assistance Programs (Cost Relief)

If you qualify for certain non-needs based drug cost share assistance programs offered by drug manufacturers (either directly or indirectly through third parties) to reduce the Deductible, Copayment, or Coinsurance you pay for certain Specialty Drugs, the reduced amount you pay may be the amount we apply to your Deductible and/or Out-of-Pocket Limit when the Prescription Drug is provided by an In-Network Provider.

As part of your benefits, you have access to Cost Relief, a program that provides benefits for certain Specialty Drugs without you having to pay Plan cost share amounts because of the availability of cost share assistance programs for Specialty Drugs. We will work with manufacturers to get the maximum cost share assistance you are eligible for and will manage enrollment and renewals on your behalf. If the manufacturers assistance is not sufficient to pay the full amount of the Plan cost share amounts, the Plan will pay the remaining balance.

Please note that Anthem may increase the cost share listed in the Schedule of Benefits in order to take full advantage of cost share assistance that is available from drug manufacturers. Any increase in the cost share will not be more than 50% of the Maximum Allowed Amount. This will lower plan costs but will not increase your cost because any additional cost share will be offset by Cost Relief.

In addition, because certain Specialty Drugs are not classified as "essential health benefits" under the Plan in accordance with the Affordable Care Act, any Member cost-share payments for these Specialty Drugs will not count towards the Plan's Deductible or Out-of-Pocket Limit and will not be paid at 100% of the Maximum Allowed Amount after the Out-of-Pocket Limit is reached. A list of Specialty Drugs that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a Specialty Drug that is not an essential health benefit is medically necessary for a particular individual.

Participation in this program is voluntary. If you currently take one or more Prescription Drugs included in this program, we will automatically enroll you in the program and send you a welcome letter, followed up with a phone call that provides specific information about the program as it pertains to your medication. Whether you enroll in Cost Relief or not, any non-needs based cost-share assistance you receive will not accumulate to your Deductible or Out-of-Pocket Limit.

If you or a covered family member are not currently taking but will start a new Prescription Drug covered under this program, you can either contact us or we will proactively contact you so that you can take full advantage of the program.

Some drug manufacturers will require you to sign up to take advantage of the assistance that they provide. In those cases, we will contact you to let you know what you need to do.

The list of Prescription Drugs covered by Cost Relief may be updated periodically by the Plan. Please refer to our website, www.anthem.com, for the latest list.

Opting Out

If you do not wish to participate in this program, you can opt out, and you will be responsible for a portion of the cost of the Specialty Drug as noted in the Schedule of Benefits.

President

Schedule of Benefits

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

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

To get the highest benefits at the lowest Out-of-Pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service.

The Federal No Surprises Act and Ohio's Surprise Billing law (House Bill 388) establish patient protections including from Out-of-Network Providers' surprise bills ("balance billing") for Emergency Care and other specified items or services. We will comply with these new state and federal requirements including how we process claims from certain Out-of-Network Providers. The Federal and state requirements are described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. 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 read the "Claims Payment" section for more details.

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

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**
- **Mental health and substance use disorder services, including behavioral health treatment,**
- **Prescription drugs,**
- **Rehabilitative and habilitative services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**
- **Chronic disease management and pediatric services, including oral and vision care.**

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

Benefit Period	Plan Year
Dependent Age Limit	To the end of the month in which the child attains age 26. Please refer to that section for further details.

Deductible	In-Network	Out-of-Network
Per Member	$500	$1,000
Per Family	$1,000	$2,000

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

When the Deductible applies, you must pay it before benefits begin. Please see the sections below to find out when the Deductible applies. No one person will pay more than their individual Deductible amount.

The Deductible does not include amounts you pay for following benefits:

- Services from Student Health Center (SHC).
- Services when a Copayment applies as shown below.
- Services listed under "Pediatric Vision Services for Members Age 19 and Older."
- Diagnostic and Preventive Services listed under "Pediatric Dental Services For Members Through Age 18."
- Retail Pharmacy and Home Delivery (Mail Order) Prescription Drugs.

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

Coinsurance	In-Network	Out-of-Network
Plan Pays	80%	60%
Member Pays	20%	40%

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.

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

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	$5,500	$10,000
Per Family	$11,000	$22,000

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

No one person covered under a family plan will pay more than their individual Out-of-Pocket Limit in a year before services are covered at 100% even if the family Out-of-Pocket maximum has not been met. Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments.

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

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

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

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services."	
Ambulance Services (Ground, Air and Water) Emergency Services For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services or services covered under Ohio's House Bill 388. For air ambulance services, Out-of-Network Providers cannot bill for you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment.	20% Coinsurance after Deductible	
Ambulance Services (Ground, Air and Water) Non-Emergency Services For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services or services covered under Ohio's House Bill 388. For air ambulance services, Out-of-Network Providers cannot bill for you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment. **Important Note:** All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.	20% Coinsurance after Deductible	
Behavioral Health Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Cardiac Rehabilitation	Please see "Therapy Services."	
Chemotherapy	Please see "Therapy Services."	

Benefits	In-Network	Out-of-Network
Clinical Trials	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."	
Pediatric Dental Services For Members Through the end of the month in which they turn 19 ***Note:*** To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
• Diagnostic and Preventive Services	0% Coinsurance	0% Coinsurance
• Basic Restorative Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible
• Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Periodontal Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prosthodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Dental Services (All Members / All Ages) Coverage for dental services is limited to certain medical services and treatment of an accidental injury.	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."	
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care." Benefits for diabetic education are based on the setting in which Covered Services are received.	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Diagnostic Services	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."	
Dialysis/Hemodialysis	Please see "Therapy Services."	
Durable Medical Equipment (DME), Medical Devices, and Supplies	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
Prosthetics	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period, In- and Out-of-Network combined	
The cost-shares listed above apply when your Provider submits separate bills for the equipment or supplies.		
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$125 Copayment per visit plus 20% Coinsurance Copayment waived if admitted	
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon)	20% Coinsurance	
• Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	20% Coinsurance	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	
As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet, 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. Please refer to the Notice at the beginning of this Booklet for more details.		
Gene Therapy Services • Precertification required	Benefits are based on the setting in which Covered Services are received and limited to an Approved Gene Therapy Provider. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."	

Benefits	In-Network	Out-of-Network
	Please note that if the covered gene therapy service is received from an Approved Gene Therapy Out-of-Network Provider you may also still be liable for the difference between the Plan's Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim involves a Surprise Billing Claim. **The difference you may be liable for can be substantial for this therapy.**	
Habilitative Services	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services." Please see "Therapy Services" for details on Benefit Maximums except as described below.	
Habilitative Services - Autism	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services."	
• Speech and Language therapy	20 visits per Benefit Period, In- and Out-of-Network combined	
• Occupational therapy	20 visits per Benefit Period, In- and Out-of-Network combined	
The visit limits for Speech and Language therapy and Occupational therapy for treatment of Autism are in addition to the limits listed under Therapy Services.		
Home Health Care		
• Home Health Care Visits from a Home Health Care Agency	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Home Dialysis	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Home Infusion Therapy/ Chemotherapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Specialty Prescription Drugs	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Home Health Care Services / Supplies	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Private Duty Nursing	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Home Health Care Benefit Maximum	100 visits per Benefit Period, In- and Out-of-Network combined. The limit includes Therapy Services (e.g., physical, speech, occupational, cardiac and pulmonary rehabilitation) given as part of the Home Health Care benefit. The limit does not apply to Home Infusion Therapy, Home Dialysis, or Private Duty Nursing.	
Home Infusion Therapy	Please see "Home Health Care."	
Hospice Care		
• Home Hospice Care	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Bereavement	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Inpatient Hospice	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Outpatient Hospice	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Respite Care	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.		
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Skilled Nursing Facility	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Rehabilitation	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Facility	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Residential Treatment Center	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Ancillary Services	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility Benefit Maximum	150 days per Benefit Period, In- and Out-of-Network combined	

Benefits	In-Network	Out-of-Network
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Surgery	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Maternity	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Services	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
Maternity and Reproductive Health Services		
Maternity Visits (Global fee for the ObGyn's prenatal, postnatal and delivery services)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Inpatient Services (Delivery)	Please see "Inpatient Services"	
• Male Sterilization	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services."	
• Female Sterilization	Covered under "Preventive Care"	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Use Disorder Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Occupational Therapy	Please see "Therapy Services."	
Office and Home* Visits		
*Home visits are not the same as Home Health Care. For Home Health Care benefits, please see the "Home Health Care" section.		
• Student Health Center (SHC) (Exclusions and limitations under this Plan do not apply to these services)	No Copayment, Deductible, or Coinsurance applies to these services	Not Applicable
• Primary Care Physician / Provider (PCP) (Including In-Person and/or Virtual Visits)	$25 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Specialty Care Physician / Provider (SCP) (Including In-Person and/or Virtual Visits)	$25 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Retail Health Clinic Visit	$25 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Preferred Online Visits (Including Mental Health & Substance Use Disorder Services)	$25 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Other Online Visits (Including Mental Health & Substance Use Disorder Services)	$25 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Counseling- Includes “Non-Preventive” Family Planning and Nutritional Counseling (Other Than Eating Disorders)	$25 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Nutritional Counseling for Eating Disorders	$25 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Allergy Testing	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Shots/Injections (other than allergy serum)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	$25 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Diagnostic X-ray	$25 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$25 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Office Surgery	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Physical Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Speech Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Occupational Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Dialysis / Hemodialysis	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
– Cardiac Rehabilitation	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Pulmonary Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
Please see "Therapy Services" for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (includes allergy serum)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
Orthotics	Please see "Durable Medical Equipment (DME) and Medical Devices, Medical and Surgical Supplies."	
Outpatient Facility Services		
Important Note on Office Visits at an Outpatient Facility If your PCP or SCP office visit is billed from an Outpatient Facility, the services will be payable the same as in an office setting. Please refer to the Office and Home* Visits section in this Schedule of Benefits for details on the cost shares that will apply.		
• Facility Surgery Charge	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Facility Surgery Lab	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Facility Surgery X-ray	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Ancillary Services	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Doctor Surgery Charges	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Allergy Shots / Injections (including allergy serum)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests (EKG, EEG, etc.)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Therapy:		
– Chiropractic / Osteopathic / Manipulative Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Physical Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Speech Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Occupational Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Dialysis / Hemodialysis	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Cardiac Rehabilitation	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
– Pulmonary Therapy	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
Please see “Therapy Services” for details on Benefit Maximums.		
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
Physical Therapy	Please see “Therapy Services.”	
Preventive Care	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
Prosthetics	Please see “Durable Medical Equipment (DME), Medical Devices, and Supplies.”	

Benefits	In-Network	Out-of-Network
Pulmonary Therapy	Please see "Therapy Services."	
Radiation Therapy	Please see "Therapy Services."	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services." Please see "Inpatient Services" and "Therapy Services" for details on Benefit Maximums.	
Respiratory Therapy	Please see "Therapy Services."	
Skilled Nursing Facility	Please see "Inpatient Services."	
Speech Therapy	Please see "Therapy Services."	
Surgery	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."	
Therapy Services (Review of Medical necessity will be performed after 12 visits)	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an Inpatient stay, look up "Inpatient Services."	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
• Physical Therapy (Rehabilitative)	Unlimited	

Benefits	In-Network	Out-of-Network
• Physical Therapy (Habilitative)	Unlimited	
• Occupational Therapy (Rehabilitative)	Unlimited	
• Occupational Therapy (Habilitative)	Unlimited	
• Speech Therapy (Rehabilitative)	Unlimited	
• Speech Therapy (Habilitative)	Unlimited	
• Manipulation Therapy	26 visits per Benefit Period	
• Cardiac Rehabilitation	36 visits per Benefit Period	

Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.

Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Health Care Visit limit will apply instead of the Therapy Services limits listed above.

Note: The visit limits for physical, occupational and speech therapy for habilitative services are separate from the visit limits for physical, occupational and speech therapy you get for any other rehabilitative therapy service.

Note: When you get occupational and speech therapy for Autism, the limits under Habilitative Services - Autism are in addition to the Therapy Services limits listed above.

Transplant Services	Please see “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services.”	

Urgent Care Services (Office and Home* Visits)

*Home visits are not the same as Home Health Care. For Home Health Care benefits, please see the "Home Health Care" section.

• Urgent Care Visit Charge	$35 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Allergy Testing	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Shots/ Injections (other than allergy serum)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	$35 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Diagnostic X-ray	$35 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$35 Copayment per visit plus 20**%** Coinsurance	40% Coinsurance after Deductible
• Office Surgery (including anesthesia)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (other than allergy serum)	20**%** Coinsurance after Deductible	40% Coinsurance after Deductible
Note: If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		
Telemedicine/Telehealth Visits and Virtual Visits	We will provide coverage for telemedicine services on the same basis and to the same extent that the Plan provides Covered Services for in-person Covered Services For services in the office please see the "Office and Home Visits" section. For Mental Health and Substance Use Disorder Services, also refer to the "Mental Health and Substance Use Disorder Services" section.	
Pediatric Vision Services For Members Through the end of the month in which they turn 19 ***Note:*** To get the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding a Blue View Vision Provider, please call us at the number on the back of your ID card. Out-of-Network providers may bill you for any charges that exceed the plan's Maximum Allowed Amount.		
• Routine Eye Exam Limited to one exam per Benefit Period	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
• Standard Plastic or Glass Lenses Limited to one set of lenses per Benefit Period.		
Single Vision	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Bifocal	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Trifocal	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Standard Progressive	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount

Benefits	In-Network	Out-of-Network
Lenticular	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Note: Covered lenses include the following lens options at no additional cost when received In Network: factory scratch coating; UV protective coating; standard polycarbonate lenses; standard photochromic or photosensitive lenses; blended segment lenses; intermediate vision lenses; progressive lenses; polarized lenses; anti-reflective coating; hi-index lenses; fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses.		
• Frames Limited to one set of frames from the Anthem Formulary per Benefit Period.	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
• Contact Lenses Elective or non-elective contact lenses from the Anthem formulary are covered once per Benefit Period per Member.		
Elective Contact Lenses (Conventional or Disposable)	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Non-Elective Contact Lenses	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Standard Contact Lens Fitting and Evaluation	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Important Note: Benefits for contact lenses are in lieu of your eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next Benefit Period.		
• Low Vision		
Comprehensive Low Vision Exam Limited to one exam per Benefit Period	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount
Optical/Non-optical aids/Supplemental Testing Limited to one occurrence of either optical/non-optical aids or supplemental testing per Benefit Period	$0 Copayment	$0 Copayment up to the Plan's Maximum Allowed Amount

Benefits	In-Network	Out-of-Network
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received. For services in the office, look up "Office and Home Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services"	

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

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

Centers of Excellence (COE) 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.

In-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.

The requirements described below do not apply to the following:

- Cornea transplants, which are covered as any other surgery; and
- Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

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

Benefits	In-Network	Out-of-Network
	In-Network Transplant Provider	**Out-of-Network Transplant Provider**
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 and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts the day of a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Inpatient Facility Services • Precertification required	During the Transplant Benefit Period, 20% Coinsurance after Deductible Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	During the Transplant Benefit Period, you will pay 40% Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will **not** have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount.

Benefits	In-Network	Out-of-Network
		If the Provider is an Out-of-Network Provider for this Plan, you **will** have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Inpatient Professional and Ancillary (non-Hospital) Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Outpatient Facility Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Outpatient Facility Professional and Ancillary (non-Hospital) Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	20% Coinsurance after Deductible	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Transportation and Lodging Limit**	Covered, as approved by us, up to $10,000 per transplant, In- and Out-of-Network combined.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.

Benefits	In-Network	Out-of-Network
• **Donor Search Limit**	Covered, as approved by us, up to $30,000 per transplant, In- and Out-of-Network combined.	
Live Donor Health Services		
• **Inpatient Facility Services**	20% Coinsurance after Deductible	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Outpatient Facility Services**	20% Coinsurance after Deductible	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Donor Health Service Limit**	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	**In-Network**	**Out-of-Network**
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days ***Note*:** A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply. When you get a 30-day supply, one Copayment per Prescription Order will apply.	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy (In-Network and Out-of-Network)	30 days* *Please see additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
***Note*: Prescription Drugs that we are required to cover by federal law under the “Preventive Care” benefit will be covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.**		

Benefits	In-Network	Out-of-Network
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$15 Copayment per Prescription Drug	$15 Copayment per prescription for Generic Drugs plus 40% Coinsurance $30 copay per prescription for Brand Name Drugs plus 40% Coinsurance
Tier 2 Prescription Drugs	$30 Copayment per Prescription Drug	$15 Copayment per prescription for Generic Drugs plus 40% Coinsurance $30 copay per prescription for Brand Name Drugs plus 40% Coinsurance
Tier 3 Prescription Drugs	$45 Copayment per Prescription Drug	$15 Copayment per prescription for Generic Drugs plus 40% Coinsurance $30 copay per prescription for Brand Name Drugs plus 40% Coinsurance
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$37.50 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	$75 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	$112.50 Copayment per Prescription Drug	Not covered

Benefits	In-Network	Out-of-Network
Specialty Drug Copayments / Coinsurance: Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see "Specialty Pharmacy" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments / Coinsurance you pay for a 30-day supply at a Retail Pharmacy. ***Note:*** Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, or your Doctor may order, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug, as well as your Tier 1 Copayment/ Coinsurance. If a Generic Drug is not available, or if your Doctor writes "Dispense as Written" or "Do not Substitute" on your Prescription, you will only have to pay the applicable Tier 2 or Tier 3 Copayment/ Coinsurance. You will not be charged the difference in cost between the Generic and Brand Name Prescription Drug. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money yet gives the same quality. For certain higher cost generic drugs, we reserve the right, in our sole discretion, to make an exception and not require you to pay the difference in cost between the Generic and Brand Name Drug.		

How Your Plan Works

Introduction

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

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

Reminder! Your University may offer a separate program which provides coverage for medical treatment or services obtained from the Student Health Center (SHC) or University Health Services (UHS) as indicated under the Schedule of Benefits. Any such program is separate from, and its services are not covered under, this Plan. If the University offers such a program, you may be required to first go to the Student Health Center (SHC) or University Health Services (UHS). The SHC or UHS will diagnose and treat most illnesses, coordinate all your health care, and if required, refer you to an In-Network Provider.

In-Network Services

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

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

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

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

To see a Doctor, call their office:

- Tell them you are an Anthem Member.
- Have your Member Identification Card handy. The Doctor's office may ask you for your University's 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 In-Network Providers:

1. You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be

billed by your In-Network Provider(s) for any Non-Covered Services you get or when you have not followed the terms of this Booklet.

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

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

After Hours Care

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

Out-of-Network Services

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

For services from an Out-of-Network Provider:

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

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

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

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

5. You may have to file claims; and

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

Surprise Billing Claims

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

Connect with Us Using Our Mobile App

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

Our goal is to make it easy for you to find answers to your questions. You can chat with us live in the app, or contact us on our website, 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.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Search for a Provider in our mobile app.
- Contact Member Services to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

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

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

Continuity of Care

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

- An ongoing course of treatment for a chronic illness or condition. A chronic illness or condition is a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.
- An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits). An acute illness is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm.
- 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" includes treatments for Mental Health and Substance use disorders.

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

Your Cost-Shares

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

The BlueCard® Program

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

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only 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.

Getting Approval for Benefits

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

Reviewing Where Services Are Provided

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

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

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

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

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

1. You must be eligible for benefits;
2. Premium 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 (also referred to as Prior Approval) –** 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 / Investigational as those terms are defined in this Booklet.

      For admissions following Emergency Care, you, your authorized representative or Doctor must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.

For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

If you fail to get Precertification, your claim will be reviewed for coverage after it is received by us to determine if your service, treatment, admission or Prescription Drug is Medically Necessary and a Covered Service on the date you get it. As noted in the "Reviewing Where Services Are Provided" section above, coverage for or payment of the service or treatment is not guaranteed even if we decide your services are Medically Necessary. On the date you get services you must be eligible for benefits; your Fees must be paid; the service or supply must be a Covered Service; the service cannot be subject to an Exclusion under this Booklet; and you must not have exceeded any applicable limits under your Plan. Additionally, your claim must be received by us within the timeframes specified in the Notice of Claim/Claim Forms/Proof of Loss provision in the Claims Payment section of this Booklet. Please note that if the Covered Service is received from an Out-of-Network Provider you may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

- **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. If an urgent review request is not approved, the Member may proceed with an expedited external review while simultaneously pursuing an appeal through our internal appeal process. If a continued stay review request is not approved, a Member who is receiving an ongoing course of treatment may proceed with an expedited external review while simultaneously pursuing an appeal through our internal appeal process.

Both Pre-Service and Continued Stay/Concurrent Reviews will 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. Either you, the treating Provider or any Physician with knowledge of your medical condition can request an urgent pre-service or urgent continued stay/concurrent review of a service, treatment or admission for a benefit coverage determination, including for a Prescription Drug that is going to be used for the treatment of opioids. Please note that where a pre-service or continued stay/concurrent review request is required for Medication Assisted Treatment for the treatment of opioids, such requests will be considered urgent. Urgent reviews are conducted under a shorter timeframe than standard reviews. If an urgent review request is not approved, the Member may proceed with an expedited external review while simultaneously pursuing an appeal through our internal appeal process. If a continued stay review request is not approved, a Member who is receiving an ongoing course of treatment may proceed with an expedited external review while simultaneously pursuing an appeal through our internal appeal process.

- **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 we have a related clinical coverage guideline and are typically initiated by us. An example of a type of post-service review is a retrospective post-claim review. For retrospective reviews if you send us a written request, we will permit a retrospective review for a claim that is submitted where Precertification was required but not obtained if the service in question meets all of

the following:

a. The service is directly related to another service for which Precertification has already been obtained and that has already been performed.
b. The new service was not known to be needed at the time the original prior Authorized Service was performed.
c. The need for the new service was revealed at the time the original Authorized Service was performed.

Once we have received the written request and all necessary information we will review the claim for coverage and Medical Necessity. We will not deny a claim for such a new service based solely on the fact that we did not receive a Precertification approval for the new service in question.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-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 us to ask for 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 customer service 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 Precertification can be found in the formulary list here:** https://www11.anthem.com/pharmacyinformation/**. You should log into your member account to find out the correct formulary to select specific to your Plan.**

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	• The Provider must get Precertification when required
Out-of-Network/ Non-Participating	Member	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • Member will be responsible for cost of services not performed by an Approved Gene Therapy Provider.
BlueCard Provider	Member **(Except for Inpatient Admissions)**	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.

Provider Network Status	Responsibility to Get Precertification	Comments
		• **BlueCard Providers must obtain Precertification for all Inpatient Admissions.**
NOTE: For an Emergency Care admission, precertification is not required. However, you, your authorized representative or Doctor must tell us of the admission as soon as possible after your condition has been stabilized.		

How Decisions are Made

We use our clinical coverage guidelines, such as medical policy, clinical guidelines and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in this section "Prescription Drugs Administered by a Medical Provider". Medical polices and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve 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 our decision under this section of your benefits, please refer to the "Grievance and External Review Procedures" section to see what rights may be available to you.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	Requests submitted via phone or fax: 72 hours from receipt of request Requests submitted electronically: 48 hours from receipt of request
Non-Urgent Pre-service Review	Requests submitted via phone or fax: 15 calendar days from receipt of request Requests submitted electronically: 10 calendar days from receipt of 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

Type of Review	Timeframe Requirement for Decision and Notification
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 request
Non-urgent Continued Stay/Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

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

- The Provider submits a Precertification or Prior Authorization request to us for a health care service, drug, or device;
- We approve the Precertification or Prior Authorization request after determining that all of the following are true:
  1. The patient is eligible under this Plan.
  2. The health care service, drug, or device is covered under this Plan.
  3. The health care service, drug, or device meets our standards for Medical Necessity and Precertification or Prior Authorization.

- The Provider renders the health care service, drug, or device pursuant to the approved Precertification or Prior Authorization request and all of the terms and conditions of the Provider's contract with us;
- On the date the health care practitioner renders the prior approved health care service, drug, or device, all of the following are true:

  1. The patient is eligible under this Plan.
  2. The patient's condition or circumstances related to their care has not changed.
  3. The Provider submits an accurate claim that matches the information submitted by the Provider in the approved Precertification or Prior Authorization request.

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

Electronic Submission of Pre-service Reviews

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

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

Our response will state if the request is approved or denied. If denied, we will provide the specific reason for the denial. If incomplete, we will indicate the specific additional information that is required to process the request. If we request additional information required to process the request, your Provider must provide an electronic receipt to us acknowledging that the request for additional information was received.

Please note that the Appeals Procedures under the Grievance and External Review Procedures section of this Booklet are also available under this option.

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

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;

- In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of a Pre-service Review request as outlined in the Getting Approval For Benefits section of this Booklet.

This section does not apply to Emergency services.

Important Information

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

We may also select certain qualifying Providers to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future or will do so in the future for any other Provider, claim or Member. Anthem 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 ID card.

We 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 we may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

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

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

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

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

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

What's Covered

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

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

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

University Health Center Benefits

Your Plan includes benefits for Covered Services from a Student Health Center (SHC) or a University Health Services (UHS). The SHC or UHS will diagnose and treat most illnesses or injuries, coordinate all your health care, and if required, refer you to an In-Network Provider.

Allergy Services

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

Ambulance Services

Ambulance Services are covered:

- When Medically Necessary; or
- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by Us to move from a Non-Network Provider to a Network Provider.

Medically Necessary ambulance services are a Covered Service when:

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

And one or more of the following are met:

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

- From a Hospital or Skilled Nursing Facility to your home.

Please note: Ambulance services are subject to Medical Necessity reviews by us.

Emergency ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an ambulance for non-Emergency transportation, we reserve the right to select the ambulance Provider. If applicable to your Plan, please see the "Schedule of Benefits" for the maximum benefit.

You must be taken to the closest Facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, we may approve benefits for transportation to the closest Facility outside your local area.

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

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

Other Non-Covered ambulance services include, but are not limited to, trips to:

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

Important Notes on Ground, Air and Water Ambulance Benefits

Benefits are only available for air and water ambulance when it is not appropriate to use a ground 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 and water ambulance. Air and water ambulance will also be covered if you are in an area that a ground ambulance cannot reach.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air and water 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 and water ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.

Behavioral Health Services

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

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

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

        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.

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

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

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

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

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

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service;
ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Please note that under Ohio state law, to qualify for coverage, you do not have to:

1. Have the reference of a participating health professional; or
2. Provide appropriate medical and scientific information.

Dental Services
Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Plan. We evaluate the procedures submitted to us on your claim to determine if they are a covered service under this Plan.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe dental care services that are not covered, are cosmetic in nature, or exceed the benefit maximums of this Plan. While these services may be Medically Necessary for your condition, they may not be covered by this Plan. There may be other dental services available that are covered under this Plan. These other services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental service recommended by your dentist. You will have to pay for any costs that exceed the allowance, in addition to any Deductible, Copayments, or Coinsurance you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It gives you and the dentist an idea of what your Out-of-Pocket costs will be. This allows you and your dentist to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, endodontic, oral surgery, or orthodontic care.

The pretreatment estimate is recommended, but not required, for you to get benefits for Covered Services.

A pretreatment estimate does not authorize treatment or determine its Medical or Dental Necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Plan benefits in effect at the time the estimate is sent to us. This is an estimate only. Our final payment will be based on the claim that is sent to us at the time of the completed dental care service(s). Sending in other claims or changes to your eligibility or to this Plan may affect our final payment.

You can ask your dentist to send in a pretreatment estimate for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your dentist can give these to you). Pretreatment estimate requests can be sent to the address on the back of your ID card.

Dental Providers

Every plan has a network of dentists to choose from. You can go to any dentist, whether they're in your network or not. But you'll almost always pay less for the same level of care if you see a dentist in your network. Also, dentists in your network will send claims for care directly to us. When you go out of network, you may have to pay up front — then you'll submit claims to us for reimbursement.

For help finding a dentist in your network, log in to www.anthem.com and go to Find a Doctor. When it asks for the type of doctor, choose dentist. You can also call the Member Services number on your dental ID card for help.

Pediatric Dental

This Plan covers the dental services below for Members through age 18 when they are performed by a licensed dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. Benefits for Members through age 18 will continue through the end of the month that the Member turns 19. If there is more than one professionally acceptable treatment for your dental condition, the Plan will cover the least expensive treatment.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per 12-month period.

Comprehensive oral evaluations will be covered once per dental office, up to the 2 times per 12-month period limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per 12-month period limit will apply.

Radiographs (X-rays)

- Bitewings – 2 series per 12-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Extraoral film.

Dental Cleaning (Prophylaxis) – Covered 2 times per 12-month period. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Note: A prophylaxis performed on a Member under the age of 14 will be covered as a child prophylaxis. A prophylaxis performed on a Member age 14 or older will be covered as an adult prophylaxis.
Fluoride Treatment (Topical application of fluoride) Covered 2 times per 12-month period.

Fluoride Varnish Covered 2 times per 12-month period.

Sealants or Preventive Resin Restorations Any combination of these procedures is covered once per 36-month period for permanent first and second molars.

Space Maintainers

Recement Space Maintainer

Basic Restorative Services

Emergency Treatment for the temporary relief of pain or infection.

Consultations with a dentist other than the one providing treatment.

Office Visits

Amalgam (silver) Restorations Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The Member must pay the difference in cost between the Plan's Maximum Allowed Amount for the Covered Service and the dentist's submitted fee for the optional treatment, plus any applicable Deductible or Coinsurance for the Covered Service.

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment.

Any combination of this procedure and dental cleanings (please see the "Diagnostic and Preventive" section) is covered 4 times per 12-month period.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- **Periodontal scaling & root planing** Covered 1 time per quadrant per 24 months.
- **Full mouth debridement** - Covered once per lifetime.

Partial Pulpotomy for apexogenesis Covered 1 time per lifetime on permanent teeth only.

Pin Retention

Pre-fabricated or Stainless Steel Crown Covered 1 time per 60-month period for eligible Dependent children through the age of 14.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Therapeutic Drug Injection

Basic Extractions
- Removal of coronal remnants (retained pieced of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Endodontic Services

Endodontic therapy on primary teeth

- Pulpal Therapy
- Therapeutic Pulpotomy.

LIMITATION: If a root canal is within 45 days of a therapeutic pulpotomy, it not a covered service since it is considered a part of the root canal procedures and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments

- Apexification
- Apicoectomy
- Root amputation
- Hemisection
- Retrograde filling

Periodontal Services

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Soft tissue allograft;

Only one complex surgical periodontal service is covered per 36-month period per single permanent tooth or multiple teeth in the same quadrant.

The following complex surgical periodontal care services are not subject to the benefit frequency stated above:

- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;

Crown Lengthening

Oral Surgery Services

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Alveoloplasty
- Removal of exostosis-per site

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product – Covered one time per 36-month period
- Excision or pericoronal gingival

- Tooth reimplantation of accidentally evulsed or displaced tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia – Covered when performed in connection with covered complex surgical services.

General anesthesia, intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

Major Restorative Services

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Plan's Maximum Allowed Amount for the Covered Service and the dentist's submitted fee for the optional treatment, plus any applicable Deductible and/or Coinsurance for the Covered Service.

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once per 5 year period if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.

We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any applicable Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Crown/Inlay/Onlay Repair

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once per 5 years when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Clasp(s)

Replacement of broken artificial teeth

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments

Partial and Bridge Adjustments

Removable Prosthodontic Services (Dentures and Partials) Covered once per 5-year period:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthodontic Services (Bridge) Covered once every 5-year period:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care. You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Dentally Necessary Orthodontic Care is a service for pediatric Members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. To be considered Dentally Necessary Orthodontic Care at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

Orthodontic treatment may include the following:

- **Limited Treatment** Treatments which are not full treatment cases and are usually done for minor tooth movement.

- **Interceptive Treatment** A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.

- **Comprehensive (complete) Treatment** Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.

- **Removable Appliance Therapy** An appliance that is removable and not cemented or bonded to the teeth.

- **Fixed Appliance Therapy** A component that is cemented or bonded to the teeth.

- **Pre-Orthodontic and Periodic Orthodontic Treatment Visits**

- **Complex Surgical Procedures** Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Note: Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six-month intervals thereafter, until treatment is completed, or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services (All Members / All Ages)

Related to Accidental Injury

Your plan includes coverage for dental work and oral surgery if they are 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 patient's condition. Injury as a result of chewing or biting is not considered an Accidental Injury unless the chewing or biting results from a medical or mental condition. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- anesthesia.

Other Dental Services

The Plan also includes coverage for dental services to prepare the mouth for medical services and treatments for:

- Transplant preparation.
- Initiation of immunosuppressives.
- Treatment related to an Accidental Injury as stated above.
- Cancer or cleft palate.

The only other dental expenses that are Covered Services are Outpatient Facility Services.

Benefits are also payable for the removal of teeth or for other dental processes only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self-management training if you have insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

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

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

Diagnostic Services

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

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.
- Genetic tests, when allowed by us.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

For Diagnostic services other than those approved to be received in a Physician's office, you may be required to use Our independent laboratory In-Network Provider called the Reference Laboratory Network (RLN). If Diagnostic Services are received at an Out-of-Network Provider, benefits will be paid at the Out-of-Network level.

Dialysis

Please see "Therapy Services" later in this section.

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

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1. The equipment, supply or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do *not* include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliance described below.

Medical and Surgical Supplies

Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Our Prescription Drug benefit or if the supplies, equipment or appliances are not received from the PBM's Home Delivery Service or from an In-Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to, Depo-Provera and Remicade.

Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

- Allergy serum extracts
- Chem strips, Glucometer Lancets

- Clinitest
- Needles/syringes
- Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include but are not limited to:

- Adhesive tape, band aids, cotton tipped applicators
- Arch supports
- Doughnut cushions
- Hot packs, ice bags
- Vitamins
- Medijectors

If you have any questions regarding whether a specific medical or surgical supply is covered, call the Member Services number on the back of your Identification Card or visit Our website at www.anthem.com.

Durable Medical Equipment

The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

- Hemodialysis equipment
- Crutches and replacement of pads and tips
- Pressure machines
- Infusion pump for IV fluids and medicine
- Glucometer
- Tracheotomy tube
- Cardiac, neonatal and sleep apnea monitors
- Augmentive communication devices are covered when We approve based on the Member's condition.

Non-Covered items may include but are not limited to:

- Air conditioners
- Ice bags/coldpack pump
- Raised toilet seats
- Rental of equipment if the Member is in a Facility that is expected to provide such equipment
- Translift chairs
- Treadmill exerciser
- Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered, call the Member Services number on the back of your Identification Card or visit Our website at www.anthem.com.

Prosthetics

Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body part and its adjoining tissues; or
- Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

- Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
- Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
- Breast prosthesis (whether internal or external) and four surgical bras per Benefit Period following a mastectomy, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
- Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
- Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered contact lenses and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
- Cochlear implant.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs following cancer treatment, limited to the maximum shown in the Schedule of Benefits.

Non-Covered Prosthetic appliances include but are not limited to:

- Dentures, replacing teeth or structures directly supporting teeth.
- Dental appliances.
- Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
- Artificial heart implants.
- Wigs (except as described above following cancer treatment).
- Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered, call the Member Services number on the back of your Identification Card or visit Our website at www.anthem.com.

Orthotic Devices

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

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.
Services provided for conditions that do not meet the definition of Emergency will not be covered.

Emergency Services

Emergency Care benefits are available in an Emergency Department or freestanding Emergency Facility and any trauma and burn center of a Hospital for services and supplies to treat the onset of symptoms for an Emergency, which is defined below.

Emergency (Emergency Medical Condition)

“Emergency” or “Emergency Medical Condition” means a medical or behavioral health condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- 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;
- Serious dysfunction of any bodily organ or part.

“Stabilize” means the provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your condition is not likely to result from or during any of the following:

- Your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- Your transfer from an emergency department or other care setting to another facility; or
- Your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Emergency Care

“Emergency Care” means a medical or behavioral health exam done in the Emergency Department of a Hospital or freestanding Emergency Facility, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. For Surprise Billing Claims, the Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable and the Out of Network Provider has complied with the notice and consent process as described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet. Your cost shares will be based on the Recognized Amount and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit.

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

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

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

Gene Therapy Services

Your Plan includes benefits for gene therapy services, when the Plan approves benefits in advance through Precertification and you use an Approved Gene Therapy Provider. See "Getting Approval for Benefits" for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an Approved Gene Therapy Provider at an approved treatment center.

Please call us to find out which Providers are Approved Gene Therapy Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.) We will help you maximize your benefits by giving you coverage information on what is covered and if any clinical coverage guidelines, medical policies or Exclusions apply. We will also be able to provide guidance on Approved Gene Therapy Providers who can provide gene therapy services.

Please note that if the covered gene therapy service is received from an Out-of-Network Provider you may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge in addition to any Coinsurance, Copayments, Deductibles, and Non-Covered charges unless your claim involves a Surprise Billing Claim. **The difference you may be liable for can be substantial for this therapy.**

Approved Gene Therapy Provider

An Approved Gene Therapy Provider is a Provider and/or Facility that has signed a specific gene therapy product pricing agreement. Only certain Providers may be qualified to provide gene therapy due to the complexity and expertise needed to deliver this treatment. Approved Gene Therapy Providers may vary based on the specific Gene Therapy being provided. The provider may be an Out-of-Network Provider. Even if a Provider is an In-Network Provider for other services it may not be an Approved Gene Therapy Provider for certain gene therapy services.

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

i. Services determined to be Experimental / Investigational; or

ii. Services provided by a non-Approved Gene Therapy Provider or at a non-approved Facility.

Habilitative Services

Benefits also include health care services and devices that help you keep, learn or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings. Please see "Therapy Services" later in this section for further details.

Habilitative services also include, but are not limited to, benefits for children (ages 0 to 21) with a medical diagnosis of autism spectrum disorder for:

- Outpatient Physical Habilitative services including:

    1. Speech and Language therapy and/or Occupational therapy, performed by a licensed therapist, limited to the visits shown in the Schedule of Benefits; and

    2. Clinical Therapeutic Intervention defined as therapies supported by empirical (factual) evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of the state of Ohio to perform the services in accordance with a treatment plan, limited to 20 hours per week.

Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans.

Home Health Care Services

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

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services.
- Diagnostic services.
- Nutritional guidance.
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.
- Therapy Services (except for Manipulation Therapy, which will not be covered when given in the home). Home Care visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical supplies.
- Durable medical equipment.

- When available in your area, benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Mental Health and Substance Use Disorder Services" section below.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private duty nursing services.

Non-Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Physician charges.
- Helpful environmental materials (hand-rails, ramps, telephones, air conditioners, and similar services, appliances and devices).
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home Infusion Therapy – Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

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

Hospice Care

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

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

- 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.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the

patient, including the immediate family, the primary or designated caregiver and individuals with significant personal ties for one year after the Member's death.

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

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

Non-Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary Human Organ and Tissue Transplants. The Human Organ and Tissue Transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- Cornea transplants; and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the collection and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

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

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

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

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

Centers of Excellence (COE) Transplant Providers

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

In-Network Transplant Provider

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

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

Out-of-Network Transplant Provider

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

Transplant Benefit Period

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

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

Prior Approval and Precertification

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

Precertification is required for a transplant. Your Doctor must certify, and we must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process.

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

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information.

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

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

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

Certain Human Organ and Tissue Transplant Services may be limited.

Infusion Therapy

Please see “Therapy Services” later in this section.

Inpatient Services

Inpatient Services include:

- Charges from a Hospital*, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.

- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic Services.
- Therapy Services.

Professional Services

- Medical care visits limited to one visit per day by any one Physician.
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time.
- Concurrent care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- Consultation which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittals via phone are excluded.
- Surgery and the administration of general anesthesia.
- Newborn exam. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

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

Maternity and Reproductive Health Services

Maternity Services

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

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

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

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section. When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of Inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within seventy-two hours after discharge.

Physician-directed follow-up care after delivery or a source of follow-up care directed by an advanced practice registered nurse after delivery is also covered. Services covered as follow-up care include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any Medically Necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage applies to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care.

Contraceptive Benefits

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

Sterilization Services

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

Abortion Services

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

Mental Health and Substance Use Disorder Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state 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 physician weekly or more often,
    - Rehabilitation and therapy.

- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs and (when available in your area) Intensive In-Home Behavioral Health Services.

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

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

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed Clinical Social Worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed Marriage and Family Therapist (L.M.F.T.),
- Licensed Professional Clinical Counselor (L.P.C.C.), or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Non-Covered Mental Health and Substance Use Disorder Services (please also see the "What's Not Covered" section of this Booklet for other Non-Covered Services):

- Custodial or Domiciliary Care.
- Supervised living or halfway houses.
- Services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled, or outward-bound programs.

Members with Mental Health or Substance Use Disorder conditions (including opioid-use disorders) have access to individual case management programs as detailed under "Health Plan Individual Case Management" in the section "Getting Approval for Benefits". Also, refer to the "Getting Approval for

Benefits" section for any Precertification and review requirements. This section defines what services, (including opioid treatment), qualify for an urgent review based on state and federal laws. To get additional information for opioid education and related issues please go to www.anthem.com and enter "opioid" in the search box.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office and Home Visits

Covered Services include:

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

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

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

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

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

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

Urgent Care as described in "Urgent Care Services" later in this section.

Prescription Drugs Administered in the Office

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

Orthotics

Please see "Durable Medical Equipment (DME), Medical Devices, and Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services for outpatient facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Freestanding Ambulatory Surgery Center, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital

site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by Us. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

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

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

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
   a. Breast cancer,
   b. Cervical cancer,
   c. Colorectal cancer,
   d. High blood pressure,
   e. Type 2 Diabetes Mellitus,
   f. Cholesterol,
   g. Child and adult obesity.

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

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

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

"Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section. If your Provider recommends coverage of a particular contraceptive service or FDA approved item based on a determination of Medical Necessity, we will defer to the determination of the Provider and cover that service or item with no Deductible, Copayments or Coinsurance from the Member when provided by a Network Provider.

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

   Prescription drugs and OTC items are limited to no more than 180-day supply per 365 days.

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a provider including:
   a. Aspirin
   b. Folic acid supplement
   c. Bowel preparations

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

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

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

- Routine screening mammograms or supplemental breast cancer screenings under state law. The total benefit for screening mammography or supplemental breast cancer screening under this Plan, regardless of the number of claims submitted by Providers, will not exceed one hundred thirty per cent (130%) of the Medicare reimbursement rate in the state of Ohio for a screening mammography or supplemental breast cancer screening. If a Provider, Hospital, or other health care facility provides a service that is a component of the screening mammography or supplemental breast cancer screening and submits a separate claim for that component, a separate payment shall be made to the Provider, Hospital, or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. The benefit paid for screening mammography or supplemental breast cancer screening constitutes full payment under this Certificate. No Provider, Hospital, or other health care facility shall seek or receive compensation in excess of the payment made for screening mammogram or supplemental breast cancer screening that corresponds to the ratio paid by Medicare in Ohio.

  For purposes of this preventive coverage benefit and the application of the total benefit limit under State law:

  - "Screening mammography" means a radiologic examination utilized to detect unsuspected breast cancer at an early stage in an asymptomatic woman and includes the x-ray examination of the breast using equipment that is dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an

average radiation exposure delivery of less than one rad mid-breast. "Screening mammography" includes digital breast tomosynthesis. "Screening mammography" includes two views for each breast. The term also includes the professional interpretation of the film. "Screening mammography" does not include diagnostic mammography.

- "Supplemental breast cancer screening" means any additional screening method deemed medically necessary by a treating Provider for proper breast cancer screening in accordance with applicable American college of radiology guidelines, including magnetic resonance imaging, ultrasound, or molecular breast imaging where either of the following conditions is met: (a) the screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the Member has dense breast tissue; or (b) the Member is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the Provider.

- Screening mammography or supplemental breast cancer screenings shall be a Covered Benefit only if performed in a healthcare Facility or mobile mammography screening unit that is accredited under the American college of radiology mammography accreditation program or in a Hospital.

- Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test).
- Child health supervision services from the moment of birth until age nine. Child health supervision services mean periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of hearing screening, by an individual acting in accordance with Ohio law. Periodic review means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Prosthetics

Please see “Durable Medical Equipment (DME), Medical Devices, and Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient’s ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include, but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Smoking Cessation

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

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

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

Covered Services include:

- Performance of accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services (All Members/All Ages)" 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.

Your Plan also covers certain oral surgeries for children. Please refer to "Pediatric Dental Services for Members Through the end of the month in which they turn 19" for details.

Reconstructive Surgery

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

Note: This section does not apply to orthognathic surgery. Please see the "Oral Surgery" section above for that benefit.

Mastectomy Notice

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

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

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Telemedicine / Telehealth Services and Virtual Visits

Please see "Virtual Visits (Telemedicine/Telehealth Visits)" later in this section.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

They are covered if provided within our guidelines.

Therapy Services

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening. It does not include massage therapy services in any setting.
- **Speech therapy and speech-language pathology (SLP) services** – Treatment for the correction of speech impairment.
- **Occupational therapy** – Treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Post-cochlear implant aural therapy –** Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents, including the cost of such agents. Please see the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Cognitive rehabilitation therapy –** Only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.
- **Dialysis/Hemodialysis –** Services of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

- **Infusion Therapy-** Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). Please see the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory (Inhalation) Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

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

Urgent Care Services

Often an urgent rather than an Emergency medical problem exists. Urgent Care services can be obtained from an In-Network or Out-of-Network Provider. However, you must obtain Urgent Care services from an In-Network Provider to receive maximum benefits. Urgent Care Services received from an Out-of-Network Provider will be covered as an Out-of-Network service and you will be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Coinsurance, Copayment or Deductible. If you experience an Accidental Injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call Your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

Virtual Visits (Telemedicine / Telehealth Visits)

Covered Services include Telemedicine / Telehealth Services. Also covered are medical chats and virtual visits. This includes visits with Providers who also provide services in person, as well as online-only Providers.

- **"**Medical Chat" means Covered Services accessed through Anthem's mobile app with a Provider via text message or chat for limited medical care. This is in addition to Telemedicine Services.

- "Telemedicine / Telehealth" means health care services provided through the use of information and

communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where either of the following is located: (a) the Member is receiving the services; (b) another health care professional with whom the provider of the services is consulting regarding the patient. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Provider to Provider discussions are also covered.

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

Benefits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside our Network, or benefit Precertification.

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

Pediatric Vision Services for Members Through the end of the month in which they turn 19

These vision care services are covered for Members through the end of the month in which they turn 19. To get the In-Network benefit, you must use a Blue View Vision Provider. For help finding one, try Find a Doctor on our website, or call us at the number on the back of your ID card. Please see the Schedule of Benefits to see your Deductible, Coinsurance, Copayment and other benefit limitations.

Routine Eye Exam

This Plan covers a complete routine eye exam with dilation, as needed. The exam is used to check all aspects of your vision.

Eyeglass Lenses

Covered standard eyeglass lenses include:

- Single vision,
- Bifocal,
- Trifocal (FT 25-28),
- Progressive, or
- Lenticular.

There are a number of additional covered lens options that are available through your Blue View Vision provider. Please see the Schedule of Benefits for the list of options.

Frames

Your Blue View Vision provider will have a collection of frames for you to choose from. They can tell you which frames are included at no extra charge and which ones will cost you more.

Contact Lenses

Each benefit period, you can get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options in a benefit period. Your Blue View Vision provider will have a collection of contact lenses for you to choose from. They can tell you which contacts are included at no extra charge and which ones will cost you more. Benefits include a contact lens fitting and evaluation.

- Elective Contact Lenses – These are contacts that you choose for comfort or appearance.

- Non-Elective Contact Lenses – These are contacts that are prescribed for the eye conditions:

  - Keratoconus, where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses;
  - pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
  - High Ametropia exceeding -12D or +9D in spherical equivalent.
  - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.
  - If contact lenses result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Note: We will not pay for non-elective contact lenses for any member who's had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Low Vision

Low vision is when you have a significant loss of vision, but not total blindness. Low vision services include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

Vision Services (All Members / All Ages)

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

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

IMPORTANT: If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, an In-Network vision care provider may charge you his or her normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request.

Prescription Drugs Administered by a Medical Provider

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

Important Details About Prescription Drug Coverage

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

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

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

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

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

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

- Quantity, dose, and frequency of administration,

- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,

- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),

- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,

- Use of an Anthem Prescription Drug List (a formulary developed by us) which is a list of FDA approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a

licensed Provider and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

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

Precertification

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

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

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

If Precertification is denied you have the right to file a Grievance as outlined in the “Grievance and External Review Procedures” section of this Booklet.

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

Designated Pharmacy Provider

Anthem 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. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with us. 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.

We may also require you to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. We reserve our 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. Anthem may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in our 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 our website at www.anthem.com.

Therapeutic Equivalents

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

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

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

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

Important Note on Prohibited Pharmacy Benefit Practices:

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

Prescription Drug Benefits

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

Prior Authorization

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

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

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

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

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

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

- Quantity, dose, and frequency of administration,

- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,

- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),

- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,

- Use of a Prescription Drug List (as described below),

- Coverage of an opioid analgesic prescribed for the treatment of chronic pain, except when the drug is prescribed to you under one of the following circumstances:

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

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

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

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Grievance and External Review Procedures” section of this Booklet.

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

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM’s Home Delivery Pharmacy.
- Specialty Drugs.
- Self-injectable insulin and syringes used for administration of insulin.
- Continuous glucose monitoring systems. Each component of the monitoring system will be subject to a separate Copayment / Coinsurance.
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for more details.

- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- Certain supplies and equipment obtained from the PBM's Home Delivery Pharmacy or from an In-Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/ Coinsurance. Contact us to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by the PBM's Home Delivery Pharmacy or from an In-Network Pharmacy then they are covered as Durable Medical Equipment (DME), Medical Devices and Supplies instead of under Prescription Drug benefits.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a member age 18 or older. These products will be covered under the "Preventive Care" benefit.
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Flu Shots (including administration). These will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- Compound ingredients within compound drugs 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.
- Drugs for off label use only when approved by Us or the PBM, or when the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the United States Department of Health and Human Services or in medical literature that meets certain criteria. Medical literature may be accepted only if all of the following apply: (1) Two articles from major peer-reviewed professional medical journals have recognized the drug's safety and effectiveness for treatment of the indication for which it has been prescribed; (2) No article from a major peer-reviewed professional medical journal has concluded that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; (3) Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States Department of Health and Human Services as acceptable peer-reviewed medical literature.
- Orally administered cancer Drugs. As required by Ohio law, your cost-share (e.g., Copayment, Deductible, or Coinsurance) will not be more than $100 per Prescription Order.

Non-Covered Prescription Drug Benefits

In addition to the Exclusions in the "What's Not Covered" section of this Booklet, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

- Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Pharmacy, unless prohibited by law.
- Drugs, devices and products, or Prescription Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over-the-counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Drugs when any version or strength becomes available over-the-counter. This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription as listed under item 6 in the "Preventive Care" section.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.

- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to Preventive Services and over-the-counter products that We must cover under federal law with a Prescription.
- Drugs which are over any quantity or age limits set by the Plan or us.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- Treatment of Onychomycosis (toenail fungus).
- Certain Prescription Drugs are not Covered Services when any version or strength becomes available over the counter. **Please contact Us for additional information on these Drugs.**
- Refills of lost or stolen medications.
- Drugs Not on the Anthem Prescription Drug List (a formulary). You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to “Prescription Drug List” in the section the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for details on requesting an exception.
- For Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by us.
- For gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, benefits may be available under the “Gene Therapy Services” benefit in the “What’s Covered” section. Please see that section for details.
- For charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
- Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- For any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.
- Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

- For therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit may be covered under the “Durable Medical Equipment and Medical Devices” benefit. Please see that section for details.
- For allergy desensitization products or allergy serum. While not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.
- Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

  If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

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

Where You Can Get Prescription Drugs

In-Network Pharmacy

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

Important Note: If we determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Pharmacies may be limited. If this happens, we may require you to select a single In-Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single In-Network Pharmacy. We will contact you if we determine that use of a single In-Network Pharmacy is needed and give you options as to which In-Network Pharmacy you may use. If you do not select one of the In-Network Pharmacies we offer within 31 days, we will select a single In-Network Pharmacy for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the “Grievance and External Review Procedures” section of this Booklet.

In addition, if we determine that you may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network Providers for Controlled Substance Prescriptions may be limited. If this happens, we may require you to select a single In-Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if you use the single In-Network Provider. We will contact you if we determine that use of a single In-Network Provider is needed and give you options as to which In-Network Provider you may use. If you do not select one of the In-Network Providers we offer within 31 days, we will select a single In-Network Provider for you. If you disagree with our decision, you may ask us to reconsider it as outlined in the “Grievance and External Review Procedures” section of this Booklet.

Maintenance Pharmacy

Please check your Schedule of Benefits. This may not apply to your Plan. You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy, please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy that lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time. We may require you or your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy.

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

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

Out-of-Network Pharmacy

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

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

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

What You Pay for Prescription Drugs

Tiers

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

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.
- *Please check your Schedule of Benefits. This may not apply to your Plan.* Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., oral, injection, topical, or inhaled). We may cover one form of administration instead of another or put other forms of administration in a different tier.

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

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

We retain the right, at our discretion, to decide coverage based upon medication dosage, dosage forms, manufacturer, and administration methods (i.e., oral, injection, topical, or inhaled) and may cover one form instead of another as Medically Necessary.

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

Exception Request for a Drug not on the Prescription Drug List

If you or your Doctor believes you need a Prescription Drug that is not on the Prescription Drug List, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the other Drugs that are on the List. We will make a coverage decision within 72 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills. If we deny coverage of the Drug, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 72 hours of

receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills.

You or your Doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the Plan. We will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If we deny coverage of the Drug, you have the right to request an external review by an IRO. The IRO will make a coverage decision within 24 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency.

Coverage of a Drug approved as a result of your request or your Doctor's request for an exception will only be provided if you are a Member enrolled under the Plan.

Step Therapy Protocol Exemption Process

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

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

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

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

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

- The required prescription drug is contraindicated for you, pursuant to the drug's United States food and drug administration prescribing information.
- You have tried the required prescription drug while under your current, or a previous, health benefit plan, or another United States food and drug administration approved AB-rated prescription drug, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
- You are stable on a prescription drug selected by your health care provider for the medical condition under consideration, regardless of whether or not the drug was prescribed when you were covered under the current or a previous health benefit plan, or have already gone through a step therapy protocol. However, we may require a stable patient to try a pharmaceutical alternative, per the federal food and drug administration's orange book, purple book, or their successors, prior to providing coverage for the prescribed drug.

This process does not prevent either of the following:

- From us requiring you to try any new or existing pharmaceutical alternative, per the federal food and drug administration's orange book, purple book, or their successors, prior to providing or renewing coverage for the prescribed drug;

- A health care provider from prescribing a prescription drug, consistent with medical or scientific evidence.

Step Therapy Prohibition for Stage 4 Cancer

We will not make coverage of a Prescription Drug that is prescribed to treat stage four advanced metastatic cancer or associated conditions dependent upon you demonstrating either of the following:

- Failure to successfully respond to a different Prescription Drug;
- A history of failing to respond to a different Prescription Drug or Drugs.

This section applies only to uses of such Prescription Drug or Drugs that are consistent with either of the following:

- An indication approved by, or described in, as applicable, either of the following for the treatment of stage four advanced metastatic cancer:
  - The United States food and drug administration;
  - The national comprehensive cancer network drugs and biologics compendium.
- The best practices for the treatment of stage four advanced metastatic cancer, as supported by peer-reviewed medical literature.

For purposes of this provision "stage four advanced metastatic cancer" means a cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body. And, "associated conditions" means the symptoms or side effects of stage four advanced metastatic cancer, or the treatment thereof, which would, in the judgment of the health care practitioner in question, jeopardize the health of a covered individual if left untreated.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the “Schedule of Benefits.” In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

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

Medication Synchronization

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

- You elect to participate in medication synchronization;
- You, the prescriber, and a pharmacist at an In-Network pharmacy agree that medication synchronization is in your best interest;
- The prescription drug to be included in the medication synchronization meets all of the following requirements:
  1. Be covered by this Plan;

2. Be prescribed for the treatment and management of a chronic disease or condition and be subject to refills;
3. Satisfy all relevant Prior Authorization criteria;
4. Not have quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized;
5. Not have special handling or sourcing needs, as determined by the Plan, that require a single, designated pharmacy to fill or refill the prescription;
6. Be formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization;
7. Not be a schedule II controlled substance, opiate, or benzodiazepine, as those terms are defined in Ohio law.

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

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

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

Therapeutic Equivalents

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

Split Fill Dispensing Program

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

Special Programs

Except when prohibited by federal regulations (such as HSA rules), from time to time we may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time.

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

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

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

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

What's Not Covered

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

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1. Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

2. Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples of Non-Covered Providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers.

3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If your School or Dependent's employer is not required to have Worker's Compensation coverage, 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.

5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.

7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

8. For court ordered testing or care unless Medically Necessary.

9. For which you have no legal obligation to pay in the absence of this or like coverage.

10. For the following:

    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For 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.

11. 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. This exclusion does not apply to Covered Services that have not been exhausted and are not paid for by another source.

12. 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.

13. For completion of claim forms or charges for medical records or reports unless otherwise required by law.

14. For missed or canceled appointments.

15. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

16. For which benefits are payable under Medicare Parts A and/or B except as required by federal law, as described in the section titled “Medicare-Eligible Members” in “General Provisions”.

17. Charges in excess of Our Maximum Allowed Amounts except for Surprise Billing Claims as outlined in the “Consolidated Appropriations Act of 2021 Notice” in the front of this Booklet.

18. Incurred prior to your Effective Date.

19. Incurred after the termination date of this coverage except as specified elsewhere in this Booklet.

20. For any 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 social 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)**.** Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Booklet. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.

21. For maintenance therapy, which is rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to “Habilitative Services” as described in the “What’s Covered” section.

22. For Custodial Care, convalescent care or rest cures.

23. For 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:

    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

24. For foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

25. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

26. For dental treatment, under the medical portion of this Plan, regardless of origin or cause, except as specified elsewhere in this Booklet. "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) or gums, including but not limited to:

    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

    This exclusion does not apply to covered dental services for Members through the end of the month in which they turn 19.

27. For 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.

28. For the following dental services:

    - Dental care for members age 19 and older, unless covered by the medical benefits of this Certificate.
    - For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.
    - Dental services or health care services not specifically covered under the Certificate (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).
    - For dental services received prior to the Effective Date of this Certificate or received after the coverage under this Certificate has ended.
    - Anesthesia services, (such as intravenous or non-intravenous conscious sedation, analgesia, nitrous oxide, and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
    - Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
    - Services of anesthesiologist, unless required by law.
    - Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
    - Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
    - Dental services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
    - Case presentations of detailed treatment plans, office visits during and after regularly scheduled hours, when no other services are performed.

- Enamel microabrasion and odontoplasty.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Temporomandibular Joint Disorder (TMJ), unless covered by the medical benefits of this Certificate.
- Oral hygiene instruction, including guidance regarding home care. Some examples of oral hygiene instructions include instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.
- Repair or replacement of lost or broken appliances.
- Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Separate services billed when they are an inherent component of another covered service.
- Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
- Additional treatment necessary to correct or relieve the results of treatment previously benefited under the Certificate.
- Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this Certificate.
- Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this Certificate.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannon satisfactorily restore the case.
- Pulp vitality tests.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Oral appliances for snoring.
- Secondary diagnostic tests in addition to the primary therapy.

29. For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or as specified elsewhere in this Booklet. The only exceptions to this are for any of the following:

- transplant preparation.
- initiation of immunosuppressives.
- treatment related to an Accidental Injury, cancer or cleft palate.

30. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly except as specified elsewhere in this Booklet.

31. Weight loss programs whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Booklet. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This Exclusion does not apply to weight management programs required under federal law as part of the "Preventive Care" benefit.

32. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Anthem plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Booklet. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

33. For marital counseling.

34. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service for Member's through the end of the month in which they turn 19. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

35. For vision orthoptic training.

36. For hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

37. For services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to, boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based, except as otherwise specified herein.

38. For services to reverse voluntarily induced sterility.

39. For diagnostic testing or treatment related to infertility except as otherwise stated as covered in the Schedule of Benefits.

40. For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;

- 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 non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Hypoallergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases;
- Sports helmets; or
- Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

41. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

42. For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. For non-Emergency Care please use the closest Network Urgent Care Center and/or your Primary Care Physician for services. As required by Ohio law, please note that coverage for Emergency Care will be provided as described in "Emergency Care Services" in the Covered Services section. Examples of non-Emergency Care may include, but are not limited to: suture removal, routine pregnancy test, sore throat, earache/infection, rashes, sprains/strains, constipation, diarrhea, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, and dental caries/cavity.

43. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK radial keratotomy or keratomileusis or excimer laser refractive keratectomy.

44. For self-help training and other forms of non-medical self-care, except as otherwise provided in this Booklet.

45. For examinations relating to research screenings.

46. For stand-by charges of a Physician.

47. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes. This exclusion does not apply to Covered Services that have not been exhausted and are not paid for by another source.

48. For Private Duty Nursing Services given in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Health Care Services benefit as specifically stated in the "Covered Services" section.

49. For Manipulation Therapy services rendered in the home as part of Home Care Services.

50. Services and supplies related to 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.

51. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupressure, or massage to help alleviate pain, treat illness or promote

health by putting pressure to one or more areas of the body, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, Bioenergetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

52. For any services or supplies provided to a person not covered under the Plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

53. For surgical treatment of gynecomastia.

54. For medical and surgical treatment of hyperhidrosis (excessive sweating).

55. For any service for which you are responsible under the terms of this Booklet to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

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

57. Complications of/or services directly related to services, supplies, or treatment related to or for problems that is a Non-Covered Service under this Booklet because it was determined by Us to be Experimental/Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.

58. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This exclusion does not apply to Preventive Services and over-the-counter products that We must cover under federal law with a Prescription as listed under item 6 in the "Preventive Care" section.

59. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

60. Treatment of telangiectatic dermal veins (spider veins) by any method.

61. Reconstructive services except as specifically stated in the "What's Covered" section of this Booklet, or as required by law.

62. Nutritional and/or dietary supplements, except as provided in this Booklet or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist. This exclusion does not apply to Covered Services received for Home Infusion Therapy under the "Home Health Care Services" benefit.

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

64. For Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis) for all indications except as described under Habilitative Services in the “What’s Covered” section unless otherwise required by law.

65. For expenses incurred for the treatment of accidents or injuries resulting from the participation in intercollegiate sport, contest or competition; traveling to or from such sport, contest or competition as a participant; or while participating in any practice or conditioning program for such sport, contest, or competition to the extent such accidents or injuries are covered by an NCAA, NAIA, or student athletic department accident or injury policy. In combination with insurance/benefits provided by these sources, students will not incur any more Out-of-Pocket costs than they, or any other student, would if covered solely by this Plan.

66. For Student Health Plan Services provided normally without charge by the health service of the University or School. This includes services covered or provided by the student health fee.

67. For certain Prescription Drugs if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

    If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

68. For delivery charges for delivery of Prescription Drugs.

69. For drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.

70. For drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

71. For drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What’s Covered" section.

72. For Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by us.

73. For drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

74. For drugs not on the Anthem Prescription Drug List (a formulary). You can get a copy of the list by calling us or visiting our website at www.anthem.com.

75. For refills of lost or stolen Drugs.

76. For physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, which are not required by law under the “Preventive Care” benefit.

77. For residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center**.** This Exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included.

78. For Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

79. Drugs not approved by the FDA.

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

81. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

82. For autopsies and post-mortem testing.

83. For any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

84. For charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.

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

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

87. For wilderness or other outdoor camps and/or programs**.**

88. Services from a Facility or Residential Treatment Center / Facility that do not fall within the definitions of "Facility" or "Residential Treatment Center / Facility" listed in the "Definitions" section.

89. Services from a Provider that does not meet the definition of Facility listed in the "Definitions" section.

90. Prosthetics for sports or cosmetic purposes.

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

92. For the following vision services:
    - Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this booklet.
    - Visual therapy, such as orthoptics or vision training, and any associated supplemental testing, unless covered under the medical benefits in this Booklet.
    - For two pairs of glasses in lieu of bifocals.
    - For plano lenses (lenses that have no refractive power).
    - For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Booklet.
    - Lost or broken lenses or frames, unless the member has reached the member's normal interval for service when seeking replacements.
    - Cosmetic lens options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
    - Safety glasses and accompanying frames.
    - Vision services not listed as covered in this Booklet.
    - For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
    - Certain benefits may be covered under the "Preventive Care" benefit. Please see that section for further details.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one of more of the criteria listed below 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 given as part of a clinical research protocol or clinical trial or is given in any other way that is meant to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or

otherwise show 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 or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we 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 reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational 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.

We have the sole authority and discretion, when allowed by state law, to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

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

Maximum Allowed Amount

General

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

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

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet 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 Booklet.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. 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" at the front of this Booklet. Please refer to that section for further details.*

When you receive Covered Services from Provider, we 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 our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we 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 an In-Network Provider or an Out-of-Network Provider.

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

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

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

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve 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 us, 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, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or

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

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

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

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

For Covered Services rendered outside our 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 we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our 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 an In-Network Provider will likely result in lower Out-of-Pocket costs to you. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com.

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

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

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, Copayment, and/or Coinsurance).

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

We 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 Non-Network Provider. Non-Covered Services are services specifically excluded from coverage by the terms of this Certificate.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

- *You choose an In-Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; Your Coinsurance responsibility when an In-Network surgeon is used is 20% of $1500, or $300. We allow 80% of $1500, or $1200. The In-Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total Out-of-Pocket responsibility would be $300.*

- *You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; Your Coinsurance responsibility for the OUT-OF-NETWORK surgeon is 30% of $1500, or $450 after the OUT-OF-NETWORK Deductible has been met. We allow the remaining 70% of $1500, or $1050.* ***In addition****, the Out-of-Network surgeon could bill you the difference between $2500 and $1500, so your total Out-of-Pocket charge would be $450 plus an additional $1000, for a total of* ***$1450****.*

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you may also 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.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:
You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a $45 Copayment for Out-of-Network Providers and a $25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of $25 and we will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your In-Network Copayment of $25, your total Out-of-Pocket expense would be $325.

Federal/State Taxes/Surcharges/Fees

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

Claims Review

Anthem 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 / Claims Forms / Proof of Loss

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

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we

will ask them for more details, and they will be required to supply those details within certain timeframes.

- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to us, or contact Member Services and ask for a claims form to be sent to you. We will send the form to you within 15 days. If you do not receive the claims form within 15 days, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

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

  Out-of-Network claims must be submitted within 90 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 90-day period. Failure to file a claim within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within such time, provided such proof is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time the claim is required to be filed. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

  Under Ohio law, you have the right to obtain an itemized copy of your billed charges from the Hospital or Facility which provided services.

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

Member's Cooperation

You will be expected to complete and submit to 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.

Payment of Benefits

We will pay benefits immediately upon, or within thirty days after we receive written notice of your claim. You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our 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. We reserve the right to make payments directly to you as opposed to any Provider for Covered Service, at our discretion. 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 Group's Plan), or that person's custodial parent or designated representative. Any payments made by us

(whether to any Provider for Covered Service or You) will discharge our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

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

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

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

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 we used for your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we 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, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount we will pay for services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID 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 us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

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

How Claims are Paid with Blue Cross Blue Shield Global Core®

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

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

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

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

When you need Blue Cross Blue Shield Global 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.

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

This Coordination of Benefits ("COB") provision applies when a person has health or dental care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern 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 in accordance with its policy terms without regard to 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.

Definitions

- A 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, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

    2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

    Each contract for coverage under (1) or (2) 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, in a COB provision, the part of the contract providing the health or dental care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health or dental care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

- The order of benefit determination rules determine whether this plan is a Primary plan or Secondary plan when the person has health or dental care coverage under more than one Plan. When this plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

- Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. 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 the person 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 a Member is not an Allowable expense.

The following are examples of expenses that are not 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 a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If a person is 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 a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall 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 shall be the Allowable expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because a Member has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, Precertification of admissions, and preferred provider arrangements.

6. The amount that is subject to the Primary high-Deductible health plan's Deductible, if We have 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 health care benefits to Members primarily in the form of services through a panel of providers which have contracted 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 a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. **Pediatric Dental Coordination of Benefits (COB).** These Pediatric Dental COB provisions (#s 1 and 2) are applicable to only the pediatric dental benefits found in the part titled What's Covered in the section Dental Services.1. If pediatric dental Essential Health Benefits are included as part of the medical plan, the medical plan will be the primary coverage and any standalone dental plan will be

secondary. 2. If the member has two medical plans, each offering pediatric dental Essential Health Benefit coverage for spouse and family, the Order of Benefits Determination rules below apply.

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

C. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation 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 shall 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 superimposed 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.

D. 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.

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

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, Student or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person 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 the person as an employee, member, policyholder, Student or retiree is the Secondary plan and the other Plan is the Primary plan.

(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:

(a) 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.
- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), We will follow the rules of that plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is 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 the rule labeled D(1) can determine the order of benefits.

(4) State continuation coverage. If a person whose coverage is provided pursuant under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, Student or retiree or covering the person as a dependent of an employee, member, Student or retiree is the Primary plan and the state 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 the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, Student or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

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

Effect On The Benefits Of This Plan

- When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

- If a Member is 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 shall not apply between that Plan and other Closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other Plans. We may get the facts We need from them 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. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Us any facts it 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, We 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. We 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 Us is more than We should have paid under this COB provision, We may recover the excess from one or more of the persons We paid or for whom We had paid, or 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.

Coordination Disputes

If you believe that We have not paid a claim properly, you should first attempt to resolve the problem by contacting Us. Follow the steps described in the "Grievance and External Review Procedures" section of the Certificate. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at *http://insurance.ohio.gov.*

Subrogation and Reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

“Recovery” means is money you receive from another, their insurer or from any "Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

These provisions apply when we pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have first priority for the benefits we have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.

- You and your legal representative must do whatever is necessary to enable us to exercise our rights and do nothing to prejudice them.

- We have the right to take whatever legal action we see fit against any party or entity to recover the benefits paid under your Plan.

- If your Recovery is less than the full value of your claim for damages as outlined in Ohio Rev. Stat. § 2323.44, our claim shall be diminished in the same proportion as your interest is diminished.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- We are not responsible for any attorney fees, other expenses or costs you incur. We further agree that 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 us.

Reimbursement

If you obtain a Recovery and we have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must promptly reimburse us to the extent of benefits we paid on your behalf from any Recovery.

- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of reimbursement, in first priority, against any Recovery.

- If your Recovery is less than the full value of your claim for damages as outlined in Ohio Rev. Stat. § 2323.44, our claim shall be diminished in the same proportion as your interest is diminished.

- You and your legal representative must hold in trust for us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to us immediately upon your receipt of the Recovery. You must reimburse us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by us.

- Any Recovery you obtain must not be dissipated or disbursed until such time as we have been repaid in accordance with these provisions.

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

    1. The amount we paid on your behalf is not repaid or otherwise recovered by us; or
    2. You fail to cooperate.

- In the event that you fail to disclose to us the amount of your settlement, we shall be entitled to deduct the amount of our lien from any future benefit under your Plan.

- We shall also be entitled to recover any of the unsatisfied portion of the amount we have paid or the amount of your settlement, whichever is less, directly from the Providers to whom we have made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and we would not have any obligation to pay the Provider.

- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved and any other information requested by us.

- You must cooperate with us in the investigation, settlement and protection of our rights.

- You must not do anything to prejudice our rights.

- You must send us 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 us if you retain an attorney or if a lawsuit is filed on your behalf.

- You must immediately notify us if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

Grievance and External Review Procedures

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

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

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

The Complaint Procedure

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

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

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

Appeal Procedures

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

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

Internal Appeals

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

You have the right to designate a representative (e.g. your Physician) to file appeals with us on your behalf and to represent you in any level of the appeals process. If a representative is seeking an appeal on your behalf, We must obtain a signed Designation of Representation (DOR) form from you. The appeal process will not begin until we have received the properly completed DOR form except that if a Physician requests expedited review of an appeal on your behalf, the Physician will be deemed to be your

designee for the limited purpose of filing for expedited review of the appeal without receipt of a signed form. We will forward a Designation of Representation form to you for completion in all other situations.

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

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

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

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

Standard Appeals

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

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

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

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

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

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

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

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

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

This section does not apply to Emergency services.

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

Expedited Appeals

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

You may request an expedited review for:

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

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

- Except as provided above, a claim involving urgent care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of your medical condition determines is a claim involving urgent care.

Exhaustion of Internal Appeals Process

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

- We agree to waive the exhaustion requirement; or
- You did not receive a written decision of our internal appeal within the required time frame; or
- We failed to meet all requirements of the internal appeal process unless the failure:

    1. Was de minimis (minor);
    2. Does not cause or is not likely to cause prejudice or harm to you;
    3. Was for good cause and beyond our control;
    4. Is not reflective of a pattern or practice of non-compliance; or

- An expedited external review is sought simultaneously with an expedited internal review.

External Review

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

"Adverse benefit determination" means a decision by a health plan issuer:

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

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

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

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

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

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

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

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

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

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

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

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

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

"Superintendent" means the superintendent of insurance.

Understanding the External Review Process

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

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

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

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

- The adverse benefit determination involves a medical judgment or is based on any medical information.

- The adverse benefit determination indicates the requested service is Experimental or Investigational, the requested health care service is not explicitly excluded in the covered person's health benefit plan, and the treating physician certifies at least one of the following:

    - Standard health care services have not been effective in improving the condition of the covered person.
    - Standard health care services are not medically appropriate for the covered person.
    - No available standard health care service covered by us is more beneficial than the requested health care service.

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

- The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.

- The covered person's treating physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.

- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.

- An expedited internal appeal is already in progress for an adverse benefit determination of Experimental or Investigational treatment and the covered person's treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

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

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

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

Request for External Review

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

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

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

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

IRO Assignment

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

IRO Review and Decision

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

The IRO will provide a written notice of its decision within 30 days of receipt by us of a request for a standard review or within 72 hours of receipt by us of a request for an expedited review. This notice will

be sent to the covered person, us and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

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

Binding Nature of External Review Decision

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

If You Have Questions About Your Rights or Need Assistance

You may contact us:

For medical and Prescription Drug or Pharmacy Issues:

Anthem Blue Cross and Blue Shield
P.O. Box 105568, Atlanta, GA 30348
To contact us by phone please call the number on back of your identification card
Fax: 1-888-859-3046
E-Mail: Ohio.Appeals@anthem.com

For "Dental Benefits for Members Through the end of the month in which they turn 19" Issues:
Anthem Blue Cross and Blue Shield
Attn: Appeals Unit
P. O. Box 1122
Minneapolis, Minnesota
55440-1122

For "Vision Benefits for Members Issues:
Blue View Vision Grievance Department
PO Box 9304
Minneapolis, MN 55440-9304

You may also contact the Ohio Department of Insurance:

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

Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Appeal Filing Time Limit

We expect that you will use good faith to file an appeal on a timely basis. However, we will not review an appeal if it is received by us after 180 days have passed since the incident leading to your appeal.

Prescription Drug List Exceptions

Please refer to the “Prescription Drug List” section in “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for the process to submit an exception request for Drugs not on the Prescription Drug List.

Eligibility and Enrollment – Adding Members

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

Who is Eligible for Coverage

The Student

All full-time registered International Students are automatically enrolled in the Plan. Full time students are eligible to enroll in the plan.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Anthem maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If Anthem discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

When You Can Enroll

Enrollment

If a Student or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Student or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact;
- Stopped receiving group contributions toward the cost of the prior health plan;
- Lost school contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Effective Date of Coverage and Special Enrollment Periods

If a Student or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan if they qualify for Special Enrollment. Except as noted otherwise below, the Student or Dependent must request Special Enrollment within 31 days of a qualifying event.

Effective Dates for Special Enrollment periods

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption unless the Subscriber timely requests a different Effective Date;
2. In the case of marriage, coverage is effective on the first day of the month after We receive a complete application, as long as the application is received within 60 days of the event; and

3. In the case where an individual loses Minimum Essential Coverage, coverage is effective based on when we receive a complete application, which must be submitted within 60 days of the qualifying event.

Effective Dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of a Student; or
4. Reduction in the number of hours of employment; or
5. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing:

    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of school contributions, and
    - Exhaustion of COBRA benefits.

Effective Dates for Special Enrollment due to loss of Minimum Essential Coverage do not include termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Updating Coverage and/or Removing Dependents

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

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination and Continuation of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled or is no longer disabled.

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

Nondiscrimination

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

Statements and Forms

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

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

Termination and Continuation of Coverage

Termination

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

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

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

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

- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents effective immediately upon Our written notice to the University.

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

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

Removal of Members

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

Information on Policy and Rate Changes

Insurance Premiums

How Premiums are Established and Changed – Premiums are the charges you and/or the University must pay us to get coverage. We figure out and set the required Premiums.

The University is responsible for paying the Premium to us according to the terms of the Contract. The University may have you contribute to the Premium cost. The University may choose to have your Premium determined by the age of the Student, with Premium set by age brackets. We may change membership Premiums on the annual date on which the University renews its coverage, or as otherwise permitted by applicable law. If the age of the Student is misstated at enrollment, all amounts payable for the correct age will be adjusted and billed to the University.

Grace Period – If the University fails to submit Premium payments to us in a timely manner, the University is entitled to a grace period of 31 days for the payment of such Premium. During the grace period, our Contract with the University shall continue in force unless the University gives us written notice of termination of the contract. If the University has obtained replacement coverage during the grace period, the Contract with us will be terminated as of the last day for which we have received Premium, and any and **all claims paid during the grace period will be retroactively adjusted to deny**. These claims that we retroactively deny should be submitted to the replacement carrier. If the University has **not** obtained replacement coverage during the grace period or fails to inform us that it has not obtained replacement coverage, we will process any and all claims with dates of service during the grace period in accordance with the terms of this Booklet.

General Provisions

Assignment

The University cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Care Coordination

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

Clerical Error

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

Confidentiality and Release of Information

Applicable state and federal law require 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 Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

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

Contract with Anthem

The University, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the University and us, Community Insurance Company dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Ohio. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in

Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The University, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Community Insurance Company and that no person, entity, or organization other than Community Insurance Company shall be held accountable or liable to the University for any of Community Insurance Company's obligations to the University created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

Note: The laws of the state in which the Group Master Contract is issued will apply unless otherwise stated herein.

This Booklet, the Contract, the University application, any riders, endorsements or attachments, and the individual applications of the Student and Dependents constitute the entire Contract between the University and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the University and any and all statements made to the University by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem.

Government Programs

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

Legal Action

You may not take legal action against us to receive benefits:

- Earlier than 60 days after we receive the claim; or
- Later than three years after the date the claim is required to be furnished to us.

Medical Policy and Technology Assessment

Anthem 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 Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

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

Medicare-Eligible Members

The Student and Dependents who are non-Medicare eligible and who reside in Ohio are eligible to enroll for coverage. A Member who is under age 65 at the time of enrollment but who later becomes eligible for Medicare Part A, B, C and/or Part D, is eligible to continue coverage with this coverage as secondary to any Medicare benefits. Medicare will be the primary carrier for such Members.

Member Rights and Responsibilities

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

It can be found on our website FAQs. To access, go to 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. Then click on the "What are my rights as a member?" question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID card.

Modifications

This Booklet allows the University to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Contract, or by mutual agreement between the University and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the University about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

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

Payment Innovation Programs

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

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

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any

Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Network Providers to us under the Program(s).

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding our standards for the collection, use, and disclosure of information gathered in connection with our business activities.

- We may collect personal information about a Member from persons or entities other than the Member.
- We may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by Us.

A more detailed notice will be furnished to you upon request.

Policies, Procedures, and Pilot Programs

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

Under the terms of the Contract, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management, care management, case management, clinical quality or wellness initiatives that may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

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

Relationship of Parties (University-Member-Anthem)

The University is responsible for passing information to you. For example, if we give notice to the University, it is the University's responsibility to pass that information to you. The University is also responsible for passing eligibility data to us in a timely manner. If the University does not give us timely

enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

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

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

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

Right of Recovery and Adjustment

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

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We reserve the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

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

Value-Added Programs

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

Value of Covered Services

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

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to test for immediate results or collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your University to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your University has selected one of these options to make available to all Students, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a University may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

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

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by, or on your behalf of to us if we have made or makes payment for the

services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

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

Accidental Injury

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

Ambulatory Surgery Center

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

Approved Gene Therapy Provider

Please see "Gene Therapy Services" in the "What's Covered" section for details.

Authorized Service(s)

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

Benefit Period

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

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Biosimilar/Biosimilars

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

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Contract with your University and is also subject to the terms of the Contract.

Brand Name Drugs

Prescription Drugs that we classify as Brand Drugs or that our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Medical Excellence (COE) Network

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

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 see the "Schedule of Benefits" for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section).

Consolidated Appropriations Act of 2021

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Controlled Substances

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

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services. Please see the 'Schedule of Benefits" for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if Precertification or Prior Authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in “Benefits After Termination.”

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the “What’s Covered” section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won’t cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the “Schedule of Benefits” for details.

Dependent

A member of the Student’s family who meets the rules listed in the “Eligibility and Enrollment – Adding Members” section and who has enrolled in the Plan.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Doctor

Please see the definition of “Physician.”

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What’s Covered" section.

Emergency Care

Please see the "What’s Covered" section.

Excluded Services (Exclusion)

Health care services your Plan doesn’t cover.

Experimental or Investigational (Experimental / Investigational)

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 We determine to be unproven. For how this is determined, please see the “What’s Not Covered” section.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, or mental health facility, as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Generic Drugs

Prescription Drugs that we classify as Generic Drugs or that our PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Group Blanket Master Contract (or Contract)

The Contract between us, Community Insurance Company, and the University (also known as the Group Blanket Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Contract is kept on file by the University. If a conflict occurs between the Contract and this Booklet, the Contract controls.

Home Health Care Agency

A Provider, licensed when required by law and approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and

2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that satisfies 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:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care

Hospital Confined/Hospital Confinement

A confinement as an Inpatient in a Hospital by reason of an illness or injury for which benefits are payable.

Identification Card (ID Card)

The card we give you that shows your Member identification, University numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see "How to Find a Provider in the Network" in the section "How Your Plan Works" for more information on how to find an In-Network Provider for this Plan.

In-Network Transplant Provider

Please see the "What's Covered" section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Program

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, please see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by us to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to 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 the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For 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;
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider;
- Not otherwise subject to an exclusion under this Certificate.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Member

People, including the Student and his or her Dependents, who has met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Use Disorder

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

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include Your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less 6 hours per day, 5 days per week.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from Your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help You access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, Prior Authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. Anthem's PBM, in consultation with Anthem, also provides services to promote and assist Members in the appropriate use of Pharmacy

benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor,
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan and Plan Year

The benefit plan your University has purchased, which is described in this Booklet. The Plan Year means the period of time by which the University renews its Contract with us.

Precertification

Please see the section “Getting Approval for Benefits” for details.

Premium

The amount that you must pay to be covered by this Plan. This may be based on your age and will depend on the University’s Contract with us.

Prescription Drug (Drug)

A substance, that under the Federal Food, Drug & Cosmetic Act, must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1) Compounded (combination) medications, when all of the ingredients are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer.
2) Insulin, diabetic supplies, and syringes.

Prescription Order

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

Primary Care Physician (“PCP”)

A Physician, in person or virtually, who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Prior Authorization

The process applied to certain Prescription Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the Pharmacy & Therapeutics Process.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, satisfies our accreditation requirements and, for In-Network Providers, and is approved by us. Details on our accreditation requirements can be found at https://www.anthem.com/provider/credentialing/. This includes any Provider that state law says we must cover when they give you Covered Services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet, please call the number on the back of your Identification Card.

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Residential Treatment Center / Facility:

An Inpatient Facility that treats 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 and be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a "walk-in" basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

A Facility licensed as a Skilled Nursing Facility in the state in which it is located that satisfies our accreditation requirements and is approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. Please see the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Student

A student who is eligible for and has enrolled in the Plan according to the rules stated under the "Eligibility" section.

Surprise Billing Claim

Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for details.

Transplant Benefit Period

Please see the "What's Covered" section for details.

University or School

The educational institution which has a Group Blanket Master Contract with us, Community Insurance Company, and which sponsors this Plan.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vl có quyЛn nhۍn miЍn phí thông tin này và sҷ trö giúp bҵng ngôn ngỹ cëa quý vl. Hãy găi cho sæ Dlch Vө Thành Viên trên thҿ ID cëa quý vl ÿӇ ÿѭӧc giúp ÿӥ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(TTY/TDD: 711)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناساییتان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpáatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim jĊzyku. W tym celu skontaktuj siĊ z Dziaáem Obsáugi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

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

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.