

**Anthem Health Plans of Maine, Inc.
d/b/a Anthem Blue Cross and Blue Shield**

**Anthem Clear Choice SG Silver Maine HMO Tiered
Options 3500/40%/9100**

Certificate of Coverage

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

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

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

THIS CERTIFICATE IS ALSO AVAILABLE AS A CHILD ONLY POLICY.

This certificate provides pediatric dental benefits.



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Notices Required by State Law

Paying Subscription Charges and Renewal

Coverage is provided as stated in the Group Agreement. The coverage will renew automatically from year to year on the Anniversary/Renewal Date for additional one-year terms unless the Group or Anthem Blue Cross and Blue Shield gives written notice of termination, subject to the provisions in the Group Agreement.

Payment for subscription charges is due the first day of each month. If payment is received within 31 days of the due date - - the grace period, coverage will continue without a lapse in coverage. If payment is not received within 31 days of the due date, coverage may be cancelled at the expiration of the grace period. We reserve the right to take necessary action to collect premiums for the grace period. We reserve the right to unilaterally modify the terms of the Contract consistent with state and federal laws.

Network Disclosure Notice

IMPORTANT NOTICE ABOUT YOUR PROVIDER NETWORK AND BENEFITS:

This is a tiered network Plan and the tiered provider network is called "Maine HMO Tiered Options". You may pay different Cost Sharing amounts (Copayments, Deductibles, Out-of-Pocket Limits and/or Coinsurance) depending on whether you receive services from a Tier 1 Network Provider or Tier 2 Network Provider. The tier of that Provider may change if the Provider changes affiliations.

There are hospitals, health care facilities, physicians or other health care providers that are not included in this plan's network. Your financial responsibilities for payment of covered services will differ substantially if you use a network provider or a non-network provider. If you use a non-network provider, there will be no benefits for services, unless they are for emergency care, ambulance services related to an emergency for transportation to a hospital, urgent care services received at an urgent care center, or we have pre-authorized them. **You are responsible for confirming that the Provider you are seeing or have been referred to see is a Network Provider for this Plan.** Please refer to the online provider directory available at Anthem.com to determine if a particular provider is in the network, and whether the Provider is in Tier 1 or Tier 2, or contact Member Service for assistance.

Network Name: Maine HMO Tiered Options

The Service Area for this plan is the State of Maine or The Service Area for this plan includes the States of Maine, New Hampshire, Connecticut, Vermont, Massachusetts and Rhode Island.

Except for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center, there is no benefit for services rendered by Non-Network Providers inside and outside the State of Maine unless the services are approved in advance by Anthem. There is no benefit for out-of-area non-Emergency Care/non-Urgent Care services, unless approved in advance by Anthem. Please see the "Claims Payment" section for further details on out-of-area services through Our Inter-Plan program.

Surprise Billing Protection Notices

Two sets of laws exist to protect Members from surprise medical bills, including both out-of-network cost sharing and balance billing amounts:

- The federal “No Surprises Act” was signed into law, as part of the Consolidated Appropriations Act, and most provisions of the Act became effective January 1, 2022.
- Maine’s surprise billing law (“An Act To Protect Maine Consumers from Unexpected Medical Bills”) became effective January 1, 2018.

This section describes the provisions of both sets of laws.

Consolidated Appropriations Act of 2021 (CAA)

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

Surprise Billing Claims

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

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at 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, 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, you will be responsible for all charges for services received post stabilization if you elect to stay at the Out-of-Network facility. 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, you knowingly elect to obtain such services, and you give informed written consent to such charges claims will not be covered. This means you will be responsible for all Out-of-Network charges for those services. 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; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

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

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

Out-of-Network Air Ambulance Services

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

How Cost-Shares Are Calculated

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

Appeals

If you receive Emergency Services from an Out-of-Network Provider 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 Surprise Billing 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 "Complaints and Appeals and External Review Procedures" section of this Benefit Book.

Provider Directories

Anthem updates the list of participating providers at least every 30 days as required by Maine law. In accordance with federal law, Anthem confirms 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 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 listing / directory of all In-Network Providers;

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

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

Maine's Surprise Billing Law

("An Act To Protect Maine Consumers from Unexpected Medical Bills")

The following only applies to Providers within the State of Maine:

A surprise bill is a bill for Covered Services, including emergency services, received by a Member for services rendered by a Non-Network Provider at a Network Provider during a service or procedure performed by a Network Provider, or during a service or procedure previously approved or authorized by us; however, a surprise bill does not include a bill for Covered Services received by a Member if a Network Provider was available and the Member knowingly elected to obtain the services from a Non-Network Provider.

With respect to a surprise bill, a Member is only responsible for what the Member would have paid (any applicable Coinsurance, Copayment, Deductible or other out-of-pocket expense) for a Network Provider. The Non-Network Provider within the State of Maine is prohibited by law from balance billing the Member.

Surprise bills for Emergency Services may be subject to the dispute resolution process provisions under Maine law.

Which Surprise Bills are Eligible for Independent Dispute Resolution

A surprise bill for covered emergency services may be eligible for an Independent Dispute Resolution (IDR) Process operated by the Maine Bureau of Insurance, if the out-of-network provider disagrees with the carrier's payment. An emergency service is a health care item or service furnished or required to evaluate and treat an emergency medical condition that is provided in an emergency facility or setting.

Process to Submit a Surprise Bill for Dispute Resolution

1. The claim must involve a surprise bill for covered emergency services.

2. The out-of-network provider requesting IDR (the “applicant”) shall submit an application to the Maine Bureau of Insurance in a form and manner prescribed by the Superintendent.

The Dispute Resolution Process

1. Within three business days after an application has been determined to be eligible, the Independent Dispute Resolution Entity (IDRE) will assign an arbitrator and notify the patient, the provider or providers, and, if applicable, the carrier or self-insured plan.

2. The arbitrator may request information at any time from the patient, the provider or providers, and the carrier, and shall advise the requested party that if a partial response or no response is received, the dispute will be decided based on the available information. Any party shall provide the information requested within the time requested, which shall be no less than five business days after the request is received, and shall attest that the information provided is true and complete.

3. The IDRE shall issue its decision within thirty days after its receipt of a completed application.

4. If the IDRE determines the carrier's payment is reasonable, payment for the dispute resolution process is the responsibility of the out-of-network provider. When the independent dispute resolution entity determines the out-of-network provider's fee is reasonable, payment for the dispute resolution process is the responsibility of the carrier. When a good faith negotiation directed by the IDRE results in a settlement between the carrier and the out-of-network provider, the carrier and the out-of-network provider shall evenly divide and share the prorated cost for dispute resolution.

5. The party responsible for payment of the IDRE's fee, or its share of the fee in the case of a negotiated settlement, must pay the IDRE within 90 days after the issuance of the decision or submission of the settlement agreement.

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 prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

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

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

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

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

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

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

Notice Regarding Breast Cancer Patient Protection Act

Under this plan, as required by the Maine Breast Cancer Patient Protection Act of 1997, coverage will be provided for inpatient care subsequent to the mastectomy, lumpectomy, or lymph node dissection for the treatment of breast cancer for a period of time determined to be medically appropriate by the attending physician in conjunction with the patient.

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

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

Mental Health Parity and Addiction Equity Act

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

Special Enrollment Notice

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

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

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

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility
- The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

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

Statement of ERISA Rights

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

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

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

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

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

Introduction

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 Group has agreed to be subject to the terms and conditions of Anthem Blue Cross and Blue Shield'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 Group Contract issued to your Group, and the Plan that your Group chose for you. The Group 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., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Blue Cross and Blue Shield. The words "you" and "your" mean the Member, Subscriber and each covered Dependent.

If you have any questions about your Plan, please be sure to call Member Service 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!

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 Service call centers. Simply call the Member Service 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 Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.



Kathleen S. Kiefer
Corporate Secretary

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Schedule of Benefits

Anthem Clear Choice SG Silver Maine HMO Tiered Options 3500/40%/9100

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" and Prescription Drugs section(s) 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 benefits under this Plan, you must get Covered Services from either a Tier 1, or a Tier 2 In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care, or Authorized Services. Please be sure to contact us if you are not sure if we have approved an Authorized Service. Benefits are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, when you use an approved 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 additional 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.

Comparable Health Care Services

Prices for the same medical services can vary greatly. Your health plan may offer an incentive to shop for low-cost, high-quality health care services, including Comparable Health Care Services, from participating

providers. “Comparable Health Care Service” means certain non-emergency, outpatient health care services in the following categories:

- Physical and occupational therapy services;
- Radiology and imaging services
- Laboratory services; and
- Infusion therapy services

If offered with your plan, incentives may be provided through the SmartShopper program and may include, but are not limited to, cash payments, gift cards or credits or reductions of premiums, copayments or deductibles. The SmartShopper program includes incentives for Comparable Health Care Services, but incentive amounts and other eligible services eligible to earn an incentive are subject to change at any time.

If the SmartShopper program is offered as part of your health plan and your provider recommends a Covered Service that is a Comparable Health Care Service or other medical test, service or procedure that is included in the SmartShopper program and eligible for an incentive, in order to earn an incentive you must:

1. Register with SmartShopper by phone 1-866-488-5441 or online at www.smartshopper.com;
2. Call or visit SmartShopper online to search for a location in your area that is eligible for an incentive before receiving the medical test, service or procedure;
3. Have the test, service or procedure at one of the locations on the SmartShopper list.

After you receive a test, service, or procedure at the cost-effective location identified by SmartShopper you should receive your incentive payment in the mail within 60 days after the claim is paid.

Please call the toll-free number on your ID Card, or visit our website www.anthem.com or www.smartshopper.com for additional information, including information on eligible services and incentive amounts.

Maine Travel Assistance Program

The Maine Travel Assistance Program will cover out of state travel to select providers in Connecticut, Massachusetts, and New Hampshire only when the member’s product includes out of state coverage and the member receives care from an In-Network Provider for specific services included in the Maine Travel Assistance Program. The travel program includes lodging and other member-related travel costs for surgeries and procedures which are not typically done in a physician’s office or Ambulatory Surgical Center (ASC). This includes Inpatient Services, including pre-testing (imaging, testing) and follow-up care and select Outpatient procedures. Please contact Member Services at the number on the back of your Identification Card (ID Card).

Benefit Period	Calendar Year
Dependent Age Limit	To the end of the month in which the child attains age 26.

Deductible	Tier 1	Tier 2
When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible, except as indicated.		
Per Member	\$3,500	\$5,300
Per Family – All other Members combined	\$7,000	\$10,600
The Tier 1 and Tier 2 Deductibles are separate and cannot be combined.		

Coinsurance	Tier 1	Tier 2
Plan Pays	60%	50%
Member Pays	40%	50%
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	Tier 1	Tier 2
Per Member	\$9,100	
Per Family – All other Members combined	\$18,200	
<p>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.</p> <p>Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period.</p>		

Out-of-Pocket Limit	Tier 1	Tier 2
<p>The Out-of-Pocket Limit does not include amounts you pay for services listed under the “Vision Services for Members Age 19 and Over”.</p> <p>No one person will pay more than their individual Out-of-Pocket Limit.</p>		

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 hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor’s office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up “Office and Home Visits.” For services in the outpatient department of a hospital, look up “Outpatient Facility Services.” For services during an inpatient stay, look up “Inpatient Services.”

Benefits	Tier 1	Tier 2
Acupuncture	Benefits are based on the setting in which Covered Services are received.	
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Ground, Air and Water) Emergency Services Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Please see “Getting Approval for Benefits” for details For ground or water ambulance services, Out of Network Providers may also bill you for any charges that exceed the Plan’s Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment.	40% Coinsurance After Deductible	

Benefits	Tier 1	Tier 2
Ambulance Services (Ground, Air and Water) Non-Emergency Services Important Note: All scheduled ground 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. For ground or water ambulance services, Out of Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment. Non-emergency Out-of-Network ambulance services are limited to \$50,000 per trip.	40% Coinsurance After Deductible Only emergency services are covered when an out of network provider is used.	
Autism Services	Benefits are based on the setting in which Covered Services are received.	
Behavioral Health Services	Mental Health and Substance Abuse 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.	
Blood Transfusions	Benefits are based on the setting in which Covered Services are received.	
Cardiac Rehabilitation	See "Therapy Services."	
Chemotherapy	See "Therapy Services."	
Chiropractor Services	See "Therapy Services."	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
COVID-19 Coverage for screening, testing and immunization	No Copayment, Deductible, or Coinsurance	Not covered
Dental Services (All Members / All Ages) (Limited to services for accidental injury, for certain Members requiring hospitalization or general anesthesia, or to prepare the mouth for certain medical treatments.)	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Dental Services for Members through Age 18:		

Benefits	In-Network	Out-of-Network
<p>Notes:</p> <p>To get In-network benefits, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call the number on the back of your ID card.</p> <p>Anesthesia for dentistry is available for certain members. Please see your Certificate of Coverage for details.</p>		
Diagnostic and Preventive Services	No Copayment, Deductible, or Coinsurance	Not covered
Basic Restorative Services	20% Coinsurance After Deductible	Not covered
Endodontic Services	50% Coinsurance After Deductible	Not covered
Periodontal Services	50% Coinsurance After Deductible	Not covered
Oral Surgery Services	50% Coinsurance After Deductible	Not covered
Major Restorative Services	50% Coinsurance After Deductible	Not covered
Prosthodontic Services	50% Coinsurance After Deductible	Not covered
Dentally Necessary Orthodontic Care	50% Coinsurance After Deductible	Not covered

Benefits	Tier 1	Tier 2
<p>Diabetes Services, Equipment, Education, and Supplies +</p> <p>Screenings for gestational diabetes are covered under "Preventive Care."</p> <p>Benefits for diabetic education are based on the setting in which Covered Services are received.</p> <p>+ Value-Based Provider: When you select a Value-Based Provider as your PCP your cost share may be waived or reduced for certain services when provided by the Value-Based Provider.</p>	40% Coinsurance After Deductible	50% Coinsurance After Deductible

Benefits	Tier 1	Tier 2
Diagnostic Services <ul style="list-style-type: none"> Preferred Reference Labs All Other Diagnostic Services 	\$25 Copayment per visit No Deductible Benefits are based on the setting in which Covered Services are received.	\$25 Copayment per visit No Deductible
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME), Medical Devices, and Supplies		
<ul style="list-style-type: none"> Durable Medical Equipment + 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Orthotics + 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Prosthetics for limb replacement 	20% Coinsurance After Deductible	20% Coinsurance After Deductible
<ul style="list-style-type: none"> All Other Prosthetics + 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Wigs 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Medical and Surgical Supplies + 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<p>+ Value-Based Provider: When you select a Value-Based Provider as your PCP your cost share may be waived or reduced for certain when provided by the Value-Based Provider.</p> <p>The cost-shares listed above apply when your Provider submits separate bills for the equipment or supplies.</p>		
Hearing Aids Benefit Maximum for Members through age 18: Benefit Maximum for Members age 19 and older:	One hearing aid per hearing-impaired ear every 36 months. Limited to \$3,000 per hearing aid for each hearing-impaired ear every 36 months.	
Wigs (when needed after cancer treatment)	Limited to 1 wig per Benefit Period	
Early Childhood Intervention Services For Members up to 36 months of age. <ul style="list-style-type: none"> Therapies Durable Medical Equipment 	\$40 Copayment per visit No Deductible 40% Coinsurance After Deductible	\$70 Copayment per visit No Deductible 50% Coinsurance After Deductible

Benefits	Tier 1	Tier 2
Emergency Room Services		
<p>Emergency Room</p> <p>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 details.</p>		
• Emergency Room Facility Charge	40% Coinsurance After Deductible	
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon)	40% Coinsurance After Deductible	
• Emergency Room Doctor Charge (Mental Health / Substance Abuse)	40% Coinsurance After Deductible	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	40% Coinsurance After Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	40% Coinsurance After Deductible	
Fertility Services	Benefits are based on the setting in which Covered Services are received.	
Habilitative Services	<p>Benefits are based on the setting in which Covered Services are received.</p> <p>See “Therapy Services” for details on Benefit Maximums</p>	

Benefits	Tier 1	Tier 2
Home Health Care <ul style="list-style-type: none"> Home Health Care Visits from a Home Health Care Agency <p>Covered Services include but are not limited to:</p> <ul style="list-style-type: none"> Intermittent skilled nursing services by an R.N. or L.P.N. Medical / social services Diagnostic services Nutritional guidance Training of the patient and/or family/caregiver Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by 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) Medical supplies Durable medical equipment 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Home Dialysis 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Home Infusion Therapy / Chemotherapy 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Specialty Prescription Drugs 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Other Home Health Care Services / Supplies 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
Home Infusion Therapy	See "Home Health Care."	
Hospice Care		
<ul style="list-style-type: none"> Home Hospice Care 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Bereavement 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Inpatient Hospice 	40% Coinsurance After Deductible	50% Coinsurance After Deductible

Benefits	Tier 1	Tier 2
<ul style="list-style-type: none"> Outpatient Hospice 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Respite Care 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<p>This Plan's Hospice benefit will meet or exceed Medicare's Hospice benefit, unless your claim involves a Surprise Billing Claim. If you use an Out-of-network Provider, that Provider may also bill you for any charges over Medicare's Hospice benefit.</p>		
<p>Human Organ and Tissue Transplant</p> <p>See "Inpatient Services" section for additional information regarding applicable cost shares.</p> <p>Please call us as soon you think you may need a transplant to talk about your benefit options. You must do this <i>before</i> you have an evaluation and/or work-up for a transplant.</p>	Benefits are based on the setting in which Covered Services are received	
Inborn Error of Metabolism: Medical Food	Benefits are based on the setting in which Covered Services are received.	
Infant Formula	Benefits are based on the setting in which Covered Services are received.	
Inpatient Services		
Facility Room & Board Charge:		
<ul style="list-style-type: none"> Hospital / Acute Care Facility 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Skilled Nursing Facility/Rehabilitation <p>Benefit Maximum: 150 Days per Benefit Period.</p>	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Rehabilitation 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Mental Health / Substance Abuse Facility 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Residential Treatment Center 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Ancillary Services 	40% Coinsurance After Deductible	50% Coinsurance After Deductible

Benefits	Tier 1	Tier 2
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Surgery	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Maternity	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Mental Health / Substance Abuse Services	40% Coinsurance After Deductible	50% Coinsurance After Deductible
Maternity and Reproductive Health Services		
• Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Inpatient Services (Delivery)	See "Inpatient Services"	
• Fertility Services	Benefits are based on the setting in which Covered Services are received.	
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 Abuse Services	Mental Health and Substance Abuse Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Occupational Therapy	See "Therapy Services."	
Office and Home* Visits Including non-routine Foot Care. Please see your Certificate of Coverage for details.		
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
Note on Office Visits at an Outpatient Facility: If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g. Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the "Outpatient Facility Services" or "Outpatient Facility Services - Site of Service Ambulatory Surgery and Radiology Centers" section, based on where services are received. Please refer to those sections for details on cost shares (e.g. Deductibles, Copayments, Coinsurance) that will apply.		
^Please note: There is no member cost share for the first primary care office visit during the plan year. First primary care visit includes Primary Care In-Person and/or Virtual Visits, Telemedicine/Telehealth, Retail Health Clinic Visits, and Walk-in Center Visits. The first office visit will accumulate across medical benefits.		
A copayment will be applied to all subsequent office visits during the plan year and are included in the deductible.		

Benefits	Tier 1	Tier 2
<ul style="list-style-type: none"> • ^Primary Care Physician / Provider (PCP) (Including In-Person and/or Virtual Visits and Ob/Gyn visits)+ <p>Copayments accumulate towards your Deductible</p>	<p>In-Person Visits</p> <p>First Visit:</p> <p>No Copayment, Deductible, or Coinsurance</p> <p>Subsequent Visits:</p> <p>\$40 Copayment per visit No Deductible</p> <p>Virtual Visits</p> <p>First Visit:</p> <p>No Copayment, Deductible, or Coinsurance</p> <p>Subsequent Visits:</p> <p>\$40 Copayment per visit No Deductible</p>	<p>In-Person Visits</p> <p>First Visit:</p> <p>No Copayment, Deductible, or Coinsurance</p> <p>Subsequent Visits:</p> <p>\$70 Copayment per visit No Deductible</p> <p>Virtual Visits</p> <p>First Visit:</p> <p>No Copayment, Deductible, or Coinsurance</p> <p>Subsequent Visits:</p> <p>\$70 Copayment per visit No Deductible</p>
<ul style="list-style-type: none"> • ^Additional Telehealth/Telemedicine Services from a Primary Care Provider (PCP) (as required by law)+ 	<p>\$40 Copayment per visit No Deductible</p>	<p>\$70 Copayment per visit No Deductible</p>
<ul style="list-style-type: none"> • Mental Health and Substance Abuse Provider (including In-Person and/or Virtual Visits) <p>Note: There is no charge for the first behavioral health office visit in each plan year. Subsequent visits will apply the PCP copayment. The first office visit cross accumulates across Mental Health and Substance Abuse benefits.</p> <p>Copayments accumulate towards your Deductible</p>	<p>In-Person Visits</p> <p>First Visit:</p> <p>No Copayment, Deductible, or Coinsurance</p> <p>Subsequent Visits:</p> <p>\$40 Copayment per visit No Deductible</p>	<p>In-Person Visits</p> <p>First Visit:</p> <p>No Copayment, Deductible, or Coinsurance</p> <p>Subsequent Visits:</p> <p>\$70 Copayment per visit No Deductible</p>

Benefits	Tier 1	Tier 2
	Virtual Visits First Visit: No Copayment, Deductible, or Coinsurance Subsequent Visits: \$40 Copayment per visit No Deductible	Virtual Visits First Visit: No Copayment, Deductible, or Coinsurance Subsequent Visits: \$70 Copayment per visit No Deductible
<ul style="list-style-type: none"> Specialty Care Physician / Provider (SCP) (Including In-Person and/or Virtual Visits) 	In-Person Visits \$80 Copayment per visit No Deductible Virtual Visits \$80 Copayment per visit No Deductible	In-Person Visits \$110 Copayment per visit After Deductible Virtual Visits \$110 Copayment per visit After Deductible
<ul style="list-style-type: none"> Additional Telehealth/Telemedicine Services from a Specialty Care Provider (SCP) (as required by law) 	\$80 Copayment per visit No Deductible	\$110 Copayment per visit After Deductible
<ul style="list-style-type: none"> ^Retail Health Clinic Visit Copayments accumulate towards your Deductible 	First Visit: No Copayment, Deductible, or Coinsurance Subsequent Visits: \$40 Copayment per visit No Deductible	First Visit: No Copayment, Deductible, or Coinsurance Subsequent Visits: \$70 Copayment per visit No Deductible
<ul style="list-style-type: none"> Counseling (includes Family Planning and Nutritional Counseling, Other Than Eating Disorders)+ 	\$40 Copayment per visit No Deductible	\$70 Copayment per visit No Deductible

Benefits	Tier 1	Tier 2
<ul style="list-style-type: none"> Nutritional Counseling for Eating Disorders <p>Note: There is no charge for the first behavioral health office visit in each plan year. Subsequent visits will apply the PCP copayment. The first office visit cross accumulates across Mental Health and Substance Abuse benefits.</p> <p>Copayments accumulate towards your Deductible</p>	<p>First Visit:</p> <p>No Copayment, Deductible, or Coinsurance</p> <p>Subsequent Visits:</p> <p>\$40 Copayment per visit No Deductible</p>	<p>First Visit:</p> <p>No Copayment, Deductible, or Coinsurance</p> <p>Subsequent Visits:</p> <p>\$70 Copayment per visit No Deductible</p>
<ul style="list-style-type: none"> Allergy Testing 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Shots / Injections (other than allergy serum) + 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Allergy Shots / Injections (including allergy serum) 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Diagnostic Lab (other than reference labs) + 	\$25 Copayment per visit No Deductible	\$25 Copayment per visit No Deductible
<ul style="list-style-type: none"> Human Leukocyte Antigen Testing – Limited to one test per lifetime per member to a maximum of \$150. Any charges incurred in excess of \$150 will be the responsibility of the member. 	<p>0% Coinsurance</p> <p>No Deductible</p>	
<ul style="list-style-type: none"> Diagnostic X-ray + 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Other Diagnostic Tests (including hearing and EKG) + 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Advanced Diagnostic Imaging (including MRIs, CAT scans) 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Office Surgery (including anesthesia) + 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
<ul style="list-style-type: none"> Therapy Services: 		
<ul style="list-style-type: none"> – Chiropractic / Osteopathic / Manipulative Therapy 	\$40 Copayment per visit No Deductible	\$70 Copayment per visit No Deductible
<ul style="list-style-type: none"> – Physical Therapy + 	\$40 Copayment per visit No Deductible	\$70 Copayment per visit No Deductible
<ul style="list-style-type: none"> – Speech Therapy 	\$40 Copayment per visit No Deductible	\$70 Copayment per visit No Deductible
<ul style="list-style-type: none"> – Occupational Therapy 	\$40 Copayment per visit No Deductible	\$70 Copayment per visit No Deductible

Benefits	Tier 1	Tier 2
– Dialysis / Hemodialysis	40% Coinsurance After Deductible	50% Coinsurance After Deductible
– Radiation / Chemotherapy / Respiratory Therapy	40% Coinsurance After Deductible	50% Coinsurance After Deductible
– Cardiac Rehabilitation	\$80 Copayment per visit No Deductible	50% Coinsurance After Deductible
– Pulmonary Therapy+	\$80 Copayment per visit No Deductible	50% Coinsurance After Deductible
See “Therapy Services” for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (other than allergy serum)+	40% Coinsurance After Deductible	50% Coinsurance After Deductible
+ Value-Based Provider: When you select a Value-Based Provider as your PCP, your cost shares may be waived or reduced when provided by the Value-Based Provider.		
Orthotics	See “Durable Medical Equipment (DME) and Medical Devices, and Supplies.”	
Outpatient Facility Services		
• Facility Surgery Charge	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Facility Surgery Lab	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Facility Surgery X-ray	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Ancillary Services	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Doctor Surgery Charges	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Other Facility Charges (for procedure rooms)	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Mental Health / Substance Abuse Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Mental Health / Substance Abuse Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	40% Coinsurance After Deductible	50% Coinsurance After Deductible

Benefits	Tier 1	Tier 2
• Shots / Injections (other than allergy serum)	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Allergy Shots / Injections (including allergy serum)	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Diagnostic Lab	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Human Leukocyte Antigen Testing – Limited to one test per lifetime per member to a maximum of \$150. Any charges incurred in excess of \$150 will be the responsibility of the member.	0% Coinsurance No Deductible	
• Diagnostic X-ray	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Other Diagnostic Tests: EKG, EEG, etc.	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Other (blood administration, removal of sutures or cast, removal of impacted or unerupted teeth, endoscopic procedures)	40% Coinsurance After Deductible	50% Coinsurance After Deductible
• Therapy:		
– Chiropractic / Osteopathic / Manipulative Therapy	40% Coinsurance After Deductible	50% Coinsurance After Deductible
– Physical Therapy	40% Coinsurance After Deductible	50% Coinsurance After Deductible
– Speech Therapy	40% Coinsurance After Deductible	50% Coinsurance After Deductible
– Occupational Therapy	40% Coinsurance After Deductible	50% Coinsurance After Deductible
– Radiation / Chemotherapy / Respiratory Therapy	40% Coinsurance After Deductible	50% Coinsurance After Deductible
– Dialysis / Hemodialysis	40% Coinsurance After Deductible	50% Coinsurance After Deductible
– Cardiac Rehabilitation	40% Coinsurance After Deductible	50% Coinsurance After Deductible
– Pulmonary Therapy	40% Coinsurance After Deductible	50% Coinsurance After Deductible
See “Therapy Services” for details on Benefit Maximums.		

Benefits	Tier 1	Tier 2
<ul style="list-style-type: none"> Prescription Drugs Administered in an Outpatient Facility (other than allergy serum) 	40% Coinsurance After Deductible	50% Coinsurance After Deductible
Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers		
<ul style="list-style-type: none"> Ambulatory Surgery Center – Facility Surgery 	\$300 Copayment per visit No Deductible	\$300 Copayment per visit No Deductible
<ul style="list-style-type: none"> Ambulatory Surgery Center – Surgery Lab 	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
<ul style="list-style-type: none"> Ambulatory Surgery Center – Surgery X-ray 	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
<ul style="list-style-type: none"> Ambulatory Surgery Center – Ancillary Services 	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
<ul style="list-style-type: none"> Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgery, Surgical Assistant) 	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
<ul style="list-style-type: none"> Radiology Center – Diagnostic X-ray 	\$75 Copayment per visit No Deductible	\$75 Copayment per visit No Deductible
<ul style="list-style-type: none"> Radiology Center – Advanced Diagnostic Imaging (including MRIs, CAT scans) 	\$250 Copayment per service No Deductible	\$250 Copayment per service No Deductible
Physical Therapy	See “Therapy Services.”	
<p>Preventive Care (including, but not limited to, colorectal screening, prostate cancer screening, mammogram, pap test, annual gynecological exam)</p> <p>Note: You may incur additional cost shares when services other than Preventive Care are rendered during a Preventive Care visit. Benefits will be based on the service code billed by your Provider.</p>	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
<p>Preventive Care for Chronic Conditions (per IRS Guidelines)</p> <ul style="list-style-type: none"> Prescription Drugs 	Please refer to the “Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits”	

Benefits	Tier 1	Tier 2
<ul style="list-style-type: none"> Medical items, equipment and screenings 	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
Please see the "What's Covered" section for additional detail on IRS guidelines		
Prosthetics	See "Durable Medical Equipment (DME), Medical Devices, and Supplies."	
Pulmonary Therapy	See "Therapy Services."	
Radiation Therapy	See "Therapy Services."	
Rehabilitation Services (including for head injuries)	Benefits are based on the setting in which Covered Services are received.	
Respiratory Therapy	See "Therapy Services."	
Skilled Nursing Facility	See "Inpatient Services."	
Speech Therapy	See "Therapy Services."	
Surgery (including, but not limited to, breast reduction surgery, symptomatic varicose vein surgery and bariatric surgery)	Benefits are based on the setting in which Covered Services are received.	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services (including but not limited to inpatient and outpatient Infusion therapy, Inhalation Therapy and Massage Therapy)	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s): Benefit Maximum(s) are for office and outpatient visits combined.		
<ul style="list-style-type: none"> Acupuncture 	12 Visits per Benefit Period	
<ul style="list-style-type: none"> Physical & Occupational Therapy (Rehabilitative) Speech Therapy (Rehabilitative) 	60 visits per Benefit Period	
<ul style="list-style-type: none"> Physical & Occupational Therapy (Medical Habilitative) Speech Therapy (Medical Habilitative) 	60 visits per Benefit Period	
<ul style="list-style-type: none"> Early Childhood Intervention Therapies 	40 visits per Benefit Period	
<ul style="list-style-type: none"> Manipulation Therapy 	Unlimited	
<ul style="list-style-type: none"> Cardiac Rehabilitation 	36 visits per Cardiac Episode	

Benefits	Tier 1	Tier 2
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice or Autism benefit.		
Note: The limits for physical, occupational, and speech therapy will not apply if you get care as part of the Mental Health and Substance Abuse benefit.		
Transplant Services	See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services.”	
Urgent Care / Walk-In Center Services (Office and Home* Visits)		
When you select a Value-Based Provider as your PCP, your cost shares may be waived or reduced for urgent care when provided by a Value-Based Provider.		
*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	\$40 Copayment per visit No Deductible	Same as Tier 1
• Allergy Testing	40% Coinsurance After Deductible	Same as Tier 1
• Shots / Injections (other than allergy serum)	40% Coinsurance After Deductible	Same as Tier 1
• Allergy Shots / Injections (including allergy serum)	40% Coinsurance After Deductible	Same as Tier 1
• Diagnostic Lab (other than reference labs)	40% Coinsurance After Deductible	Same as Tier 1
• Diagnostic X-ray	40% Coinsurance After Deductible	Same as Tier 1
• Other Diagnostic Tests (including hearing and EKG)	40% Coinsurance After Deductible	Same as Tier 1
• Human Leukocyte Antigen Testing Limited to one test per lifetime per member to a maximum of \$150. Any charges incurred in excess of \$150 will be the responsibility of the member.	0% Coinsurance No Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	40% Coinsurance After Deductible	Same as Tier 1
• Office Surgery (including anesthesia)	40% Coinsurance After Deductible	Same as Tier 1
• Prescription Drugs Administered in the Office (other than allergy serum)	40% Coinsurance After Deductible	Same as Tier 1

Benefits	Tier 1	Tier 2
If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.		
Virtual Visits (from Virtual Care Only Providers)	Virtual Care-Only Providers through our mobile app and website:	
<ul style="list-style-type: none"> ^Virtual Visits including Primary Care from Virtual Care-Only Providers (Medical Services) <p>Please note: There is no member cost share for the first primary care office visit in each plan year. First primary care visit includes Primary Care In-Person and/or Virtual Visits, Telemedicine/Telehealth, Retail Health Clinic Visits, and Walk-in Center Visits. The first office visit will accumulate across medical benefits.</p>	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
<ul style="list-style-type: none"> Virtual Visits from Virtual Care-Only Providers (Mental Health and Substance Use Disorder Services) 	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
<ul style="list-style-type: none"> Virtual Visits from Virtual Care-Only Providers (Specialty Care Services) 	\$80 Copayment per visit No Deductible	Same as Tier 1
If Preventive Care is provided during a Virtual Visit, it will be covered under the “Preventive Care” benefit, as required by law. Please refer to that section for details.		

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.	Not Covered
Vision Services Members through Age 18 To receive the In-Network benefit, you must use a Blue View Vision provider. Visit our website or call the number on your ID card for help in finding a Blue View Vision provider. Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.		

Routine Eye Exam (Once every calendar year)	\$0 Copayment	Not covered
Standard Plastic Lenses Limited to one set of lenses per calendar year per member. <ul style="list-style-type: none"> • Single Vision • Bifocal • Trifocal • Progressive Covered lenses include factory scratch coating, standard polycarbonate and standard photochromic at no additional cost when received from In-Network Providers.	\$0 Copayment \$0 Copayment \$0 Copayment \$0 Copayment	Not covered Not covered Not covered Not covered
Frames Limited to one frame from the Anthem Formulary per calendar year per member.	\$0 Copayment	Not covered
Contact Lenses Elective or non-elective contact lenses from the Anthem formulary are covered once per calendar year per member.		
Elective Contact Lenses	\$0 Copayment	Not covered
Non-Elective Contact Lenses	\$0 Copayment	Not covered
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 eyeglasses until the next benefit period.		
Low vision benefits are only available when received from Blue View Vision Providers: <ul style="list-style-type: none"> • Comprehensive low vision exam Limited to one per calendar year • Optical/Non-optical aids/Supplemental Testing Limited to one occurrence of either optical/non-optical aids or supplemental testing per calendar year.	\$0 Copayment \$0 Copayment	Not covered Not covered

Vision Services Members Over Age 18. To receive the In-Network benefit, you must use a Blue View Vision Provider. Visit our website or call the number on your ID card for help in finding a Blue View Vision Provider. Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
Routine Eye Exam (Once every calendar year)	\$20 Copayment	Not covered

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. We will cover at least one FDA-approved HIV prevention drug for each method of administration with no member cost share.		

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. Note: For FDA-approved Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies. In the event of a statewide state of emergency declared by the Governor of Maine, we will cover Prescription Drugs for up to a 180-day supply.	
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	30 days* *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.

Retail Pharmacy Copayments / Coinsurance

Note about Insulin:

The per Member Cost Share for covered prescription insulin drugs used to treat diabetes will not exceed a total of \$35 per 30-day supply when obtained from a Network Retail Pharmacy. Deductible does not apply.

	Level 1 In-Network Provider	Level 2 In-Network Provider	Out-of-Network Provider
Tier 1a No Deductible	\$5 Copayment per Prescription Drug	\$35 Copayment per Prescription Drug	Not covered
Tier 1b No Deductible	\$25 Copayment per Prescription Drug	\$40 Copayment per Prescription Drug	Not covered
Tier 2	\$50 Copayment per Prescription Drug	\$65 Copayment per Prescription Drug	Not covered
Tier 3	\$100 Copayment per Prescription Drug after Deductible	\$150 Copayment per Prescription Drug after Deductible	Not covered
Tier 4	\$250 Copayment per Prescription Drug after Deductible	\$300 Copayment per Prescription Drug after Deductible	Not covered

Note: You may also obtain up to a 90-day supply of maintenance medications at certain Maine retail pharmacies. You can learn whether your pharmacy participates in the Mail Service Prescription Drug Program by calling the Member Services Department at the number on your ID Card. A list of pharmacies participating in the program is also available online at www.anthem.com.

Home Delivery Pharmacy Copayments / Coinsurance

Note about Insulin:

The per Member Cost Share for covered prescription insulin drugs used to treat diabetes will not exceed a total of \$105 per 90-day supply when obtained from a Network Retail Pharmacy. Deductible does not apply.

	In-Network Provider	Out-of-Network Provider
Tier 1a No Deductible	\$13 Copayment per Prescription Drug	Not Covered
Tier 1b No Deductible	\$63 Copayment per Prescription Drug	Not Covered
Tier 2	\$150 Copayment per Prescription Drug	Not Covered

Tier 3	\$300 Copayment per Prescription Drug after Deductible	Not Covered
Tier 4	\$250 Copayment per Prescription Drug after Deductible	Not Covered

Specialty Drug Copayments / Coinsurance:

Please note that certain Specialty Drugs are only available from the 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 the Specialty Pharmacy, you will have to pay the same Copayments / Coinsurance you pay for a 30-day supply at a Retail Pharmacy.

Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.

How Your Plan Works

Introduction

Your Plan is a HMO Tiered plan. To get benefits under this Plan, you must get Covered Services from either a Tier 1 In-Network Provider or Tier 2 In-Network Provider. Services from an Out-of-Network Provider are not covered, except for Emergency Care, or Authorized Services. Please be sure to contact us if you are not sure if we have approved an Authorized Service.

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

This is a Tiered Network Plan. You pay different cost sharing amounts (Copayments, Deductibles, and/or Coinsurance) depending on the whether you receive services from a Tier 1 In-Network Provider or a Tier 2 In-Network Provider.

Tier 1 Providers: Most often, your cost sharing amounts are lower when you receive Covered Services from a Tier 1 Provider.

Tier 2 Providers: These providers are In-Network, but they are not preferred. Your cost sharing amounts are generally higher.

Out-of-Network Providers: Services from an Out-of-Network are not covered, except for Emergency Care, Urgent Care, or Authorized Services.

In-Network Provider Services

When you get care from an In-Network Provider or as part of an Authorized Service, benefits are available for Covered Services.

If you received 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, Covered Services will be covered at the In-Network level.

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have authority to decide the Medical Necessity of the service. You have the right to question any denied service. Please refer to the Complaints and Appeals and External Review Procedures section of this certificate for details.

Primary Care Physicians / Providers (PCP)

Your Plan requires you to select a Primary Care Physician from our network, or we will assign one. We will notify you of the PCP that we have assigned. You may then use that PCP or choose another PCP from our Provider Directory. Please see “How to Find a Provider in the Network” for more details.

PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians and qualified Certified Nurse Practitioners or other qualified primary care providers, as required by law, for services within the scope of their license. Each Member should choose a PCP who is listed in the Provider directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, call us or see our website, www.anthem.com.

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care.

If, when you first enroll (sign up) for coverage under this Plan, you are under the care of an Out-of-Network Provider, you should tell us right away. To keep getting care under this Plan from any Out-of-Network Provider, we must approve an Authorized Service with that Provider or the services will be denied.

First - Make an Appointment with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, contact their office:

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

When you meet with your PCP, be sure to bring your Member Identification Card with you. If you need to see a Specialist, please contact your PCP to get a referral. You may also receive Covered Services from a Network Provider with a referral from a Direct Primary Care Provider.

If you have any questions about Covered Services, call us at the telephone number listed on the back of your Identification Card.

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.

Surprise Billing Claims

Surprise Billing Claims are described in the "Surprise Billing Protection Notices" 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 Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need details about a Provider's license or training, or help choosing a Doctor who is right for you, call the Member Service 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.

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

Value-Based Provider Program

Certain Primary Care Providers are part of our Value-Based Provider program. When you select a Value-Based Provider as your PCP, your cost share may be waived or reduced for certain Covered Services when provided by the Value-Based Provider. See your Plan's directory for Value-Based Providers that participate in this Plan's network.

Crediting Prior Plan Coverage

If you were covered by the Group's prior carrier / plan immediately before the Group signs up with us, with no break in coverage, then you will get credit for any accrued Deductible amount under that other plan.

This does not apply to people who were not covered by the prior carrier or plan on the day before the Group's coverage with us began, or to people who join the Group later.

If your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Group offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If your Group offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Deductible, Out of Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your Group moves to this Plan at the beginning of a Benefit Period;
- You change from one of our individual policies to a group plan;
- You change employers; or

- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

Continuity of Care

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

- 1) In treatment for a serious and complex condition. This can be a sudden (acute) illness that requires specialized treatment to avoid death or permanent harm. It can also be an ongoing (chronic) illness that is life threatening or potentially disabling and requires specialized care over a long period of time.
- 2) In a hospital or other inpatient facility.
- 3) Scheduled for nonelective surgery by your current doctor, including your post-operative care for the surgery.
- 4) Pregnant (including postpartum care).
- 5) Terminally ill.

An "ongoing course of treatment" includes treatments for mental health and substance use disorders.

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

Your Cost-Shares

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

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard", which provides services to you when you are outside of our Service Area. If you are traveling outside of Maine and need care, you can find a doctor at www.Anthem.com or call us at the number on the back of your ID card. If you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center toll free number at 800-810-2583. Or you can call them collect at 804-673-1177.

For more details on these programs, please see "Inter-Plan Arrangements" in the "Claims Payment" section.

Maine Travel Assistance Program

The Maine Travel Assistance Program will cover out of state travel to select providers in Connecticut, Massachusetts, and New Hampshire only when the member's product includes out of state coverage and the member receives care from an In-Network Provider for specific services included in the Maine Travel

Assistance Program. The travel program includes lodging and other member-related travel costs for surgeries and procedures which are not typically done in a physician's office or Ambulatory Surgical Center (ASC). This includes Inpatient Services, including pre-testing (imaging, testing) and follow-up care and select Outpatient procedures. Please contact Member Services at the number on the back of your Identification Card (ID Card).

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 part of the review, services that can be safely given in a lower level of care or lower cost setting, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting. 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 setting or place of care 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 approved if provided on an outpatient basis in a Hospital setting.
- A service may be denied on an outpatient basis in a Hospital setting but may be approved at 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.

Certain services must be reviewed to determine Medical Necessity in order for you to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more effective, 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 Service 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** – 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 of the admission as soon as possible. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

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

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

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

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. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	The Provider must get Precertification when required.
Out-of-Network/ Non-Participating	Member	<p>Member has no benefit coverage for an Out-of-Network Provider unless:</p> <ul style="list-style-type: none"> • The Member gets approval to use an Out-of-Network Provider before the service is given, or. • The Member requires an Emergency Care admission (See note below.) <p>If these are true, then</p> <ul style="list-style-type: none"> • The Member must get Precertification when

Provider Network Status	Responsibility to Get Precertification	Comments
		<p>required. (Call Member Services.) 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.</p> <ul style="list-style-type: none"> Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary, not Emergency Care, or any charges in excess of the Maximum Allowed Amount.
BlueCard Provider	Member (Except for Inpatient Admissions)	<p>Member has no benefit coverage for a BlueCard Provider unless:</p> <ul style="list-style-type: none"> The Member gets approval to use a BlueCard Provider before the service is given, or. The Member requires an Emergency Care admission (See note below.) <p>If these are true, then</p> <ul style="list-style-type: none"> The Member must get Precertification when required. (Call Member Services.) 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. Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary, not an Emergency, or any charges in excess of the Maximum Allowed Amount. BlueCard Providers must obtain precertification for all Inpatient Admissions.
<p>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.</p>		

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 the section "Prescription Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. 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 "Complaints and Appeals 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
Urgent Pre-service Review	24 hours from the receipt of request
Non-Urgent Pre-service Review	72 hours, or 2 business days from the receipt of the request
Urgent/Concurrent Review Review for ongoing inpatient stay or outpatient treatment	24 hours from the receipt of the request
Concurrent Review Review for ongoing inpatient stay or outpatient treatment	1 working day after obtaining all necessary information
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.

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) if in our 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 checking your on-line Provider Directory or 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, including but not limited to Asthma, Heart Disease, Depression, Diabetes, High Blood Pressure & High Cholesterol, Low Back Pain, and Pain. 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 the 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 the "How Your Plan Works" section for more information on your Plan's rules. Read the "What's Not Covered" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have inpatient surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional 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 in 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/or how the Provider has billed the Covered Service, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details.

Please note that care must be received from your Primary Care Physician (PCP) or another In-Network Provider to be a Covered Service under this Plan. If you use an Out-of-Network Provider, your entire claim will be denied unless:

- The services are for Emergency or Urgent Care; or
- The services are approved in advance by Anthem as an Authorized Service.

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

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

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

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

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
 - From your home, the scene of 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.

- For air or water ambulance, you are taken:
 - From 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 an approved Facility.

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

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available. Please see the “Schedule of Benefits” for the maximum benefit.

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

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

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

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Autism Spectrum Disorders

Your Plan provides coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an Autism Spectrum Disorder. Treatment of Autism Spectrum Disorders is covered when it is determined by a licensed physician or licensed psychologist that the treatment is Medically Necessary Health Care, as defined in the Certificate of Coverage. A licensed physician or licensed psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually.

Behavioral Health Services

Please see “Mental Health and Substance Abuse Services” later in this section

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic Services

We provide Benefits for treating acute musculoskeletal disorders. We additionally provide Benefits for ancillary treatment, such as massage therapy, heat, and electro-stimulation, when performed in conjunction with an active course of chiropractic or manipulative/adjustive treatment. Such ancillary treatment may be subject to a deductible, based on service codes billed by the provider. Each type of service may be subject to different or multiple limits and/or other cost share, including copayments. We do not provide benefits for maintenance therapy for chronic conditions. See also “Manipulative/Adjustive Therapy”. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor.

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 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.

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; or
- 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; or
- 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.

COVID-19 Diagnosis and Prevention

We will provide coverage for the screening, testing and immunization for COVID-19. Please see the Schedule of Benefits for further details.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

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

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

Treatment of Accidental Injury

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

Dental Services for Cancer Patients

Coverage will be provided for medically necessary dental procedures for a Member who has been diagnosed with cancer. Covered services include:

- Fluoride treatment and dental procedures that are medically necessary to reduce the risk of infection or eliminate infection or to treat tooth loss or decay in a Member prior to beginning cancer treatment, including chemotherapy, biological therapy or radiation therapy treatment; and
- Dental procedures that are medically necessary to reduce the risk of infection or eliminate infection or to treat tooth loss or decay that are the direct or indirect result of cancer treatment, including chemotherapy, biological therapy or radiation therapy treatment.

Routine preventive dental care, including cleaning and sealants, are not Covered Services, except as indicated in the Pediatric Dental Covered Services section below.

Dental Procedures

The Plan will provide benefits for general anesthesia and associated facility charges for dental procedures rendered in a hospital when the member is classified as vulnerable. Examples of vulnerable members include, but are not limited to the following:

- Infants
- Individuals exhibiting physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce a superior result
- Individuals with acute infection
- Individuals with allergies
- Individuals who have sustained extensive oral-facial or dental trauma
- Individuals who are extremely uncooperative, fearful or anxious

Dental Services

Independent Practice Dental Hygienist This plan will provide benefits secondary to dental coverage, if applicable, for covered services when those services are provided and billed by an Independent Practice Dental Hygienist.

Your Dental Benefits. Dental care treatment decisions are made by you and your dentist. We cover treatment based on what benefits you have, not whether the care is medically or dentally necessary. The only exception is when you get orthodontic care — we do review those services to make sure they're appropriate.

Pretreatment Estimates. When you need major dental care, like crowns, root canals, dentures/bridges, oral surgery, or braces — it's best to go over a care or treatment plan with your dentist beforehand. It should include a "pretreatment estimate" so you know what it will cost.

You or your dentist can send us the pretreatment estimate to get an idea of how much of the cost your benefits will cover. Then you can work with your dentist to make financial arrangements, before you start treatment.

Dental Providers. To use your dental benefits, you must go to dentists in your network. For help finding a dentist in your network, log in to www.anthem.com/mydentalvision 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 COVERED SERVICES

Pediatric Dental Essential Health Benefits. The following dental care services are covered for members until the end of the month in which they turn 19. All covered services are subject to the terms, limitations, and exclusions of this plan. See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic and Preventive Services

Oral Exams. Covered 2 times per 12 months.

Radiographs (X-rays): Bitewings – 2 sets per 12 months.

- Full mouth (also called complete series) – 1 time per 60 months.
- Panoramic – 1 time per 60 months.
- Periapicals and occlusal films.

Dental Cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered 2 times per 12 months. Paid as child prophylaxis if member is 13 or younger, and adult prophylaxis starting at age 14.

Fluoride Treatment (topical application or fluoride varnish). Covered 2 times per 12 months.

Fluoride Treatment including topical application of fluoride or therapeutic fluoride varnish. Covered for members with moderate to high risk of dental decay.

Sealants or Preventive Resin Restorations. Any combination of these procedures is covered 1 time per tooth every 36 months.

Space Maintainers and Recement Space Maintainers.

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection.

Basic Restorative Services

Consultations. Covered when given by a provider other than your treating dentist.

Fillings (restorations). Fillings are covered when placed on primary or permanent teeth. There are two kind of fillings covered under this plan:

- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.
- Composite Resin. These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If you choose to have a composite resin filling placed on a back tooth, we will pay up to the maximum allowed amount for an amalgam filling. You will be responsible to pay for the difference, if the dentist charges more, plus any applicable deductible or coinsurance.

Periodontal Maintenance. This procedure includes periodontal evaluation, removing bacteria from the gum pocket areas, measuring the gum pocket areas, and scaling and polishing of the teeth. Any combination of this procedure and dental cleanings (see Diagnostic and Preventive Services above) is covered 4 times per 12 months.

Endodontic Therapy on Primary Teeth

- Pulpal therapy
- Therapeutic pulpotomy

Periodontal Scaling and Root Planing. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered 1 time per quadrant per 24 months.

Resin Based Crown

Partial Pulpotomy for Apexogenesis. Covered on permanent teeth only.

Pre-fabricated or Stainless Steel Crown. Covered 1 time per 60 months for members through the age of 14.

Pin Retention

Therapeutic Drug Injection

Basic Tooth Extractions.

- Removal of coronal remnants (pieces of the crown portion of the tooth) on primary teeth.
- Extraction of erupted tooth or exposed root.

Surgical Incision and Drainage of an Abscess.

Endodontic Services

Endodontic Therapy. The following will be covered for permanent teeth only:

- Root canal therapy.
- Root canal retreatment.

Other Endodontic Treatments

- Apexification
- Apicoectomy
- Root amputation
- Hemisection

Periodontal Services

Full Mouth Debridement. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered 1 time per lifetime.

Complex Surgical Periodontal Care. These services are surgical treatment for diseases of the gums (gingival) and bone that supports the teeth. Only one of the below services is covered per single tooth or multiple teeth in the same quadrant per 36 months. Covered for permanent teeth only.

- Gingivectomy/gingivoplasty
- Gingival flap
- Apically positioned flap

- Osseous surgery
- Bone replacement graft

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.
- Soft tissue allograft

Crown Lengthening.

Oral Surgery Services

Basic Extractions

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

Complex Surgical Extractions. Surgical removal of 3rd molars is covered only when symptoms of oral pathology exist.

Surgical removal of erupted tooth.

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

Other Complex Surgical Procedures

- Alveoplasty
- Removal of exostosis – per site

Other Oral Surgery Procedures.

- Incision and drainage of abscess (intraoral soft tissue).
- Collection and application of autologous product. Covered 1 time per 36 months.
- Excision of pericoronal gingiva.
- Tooth reimplantation (accidentally avulsed or displaced tooth).
- Suture of recent small wounds up to 5 cm.

Intravenous Conscious Sedation, IV Sedation and General Anesthesia. Covered when given with a complex surgical service. The service must be given in a dentist's office by the dentist or an employee of the dentist that is certified in their profession to give anesthesia services.

Major Restorative Services

Gold foil restorations. Gold foil restorations are covered at the same frequency as an amalgam filling. Gold foil restorations will be paid up to the same maximum allowed amount for an amalgam filling. You're responsible to pay for any amount over the maximum allowed amount, plus any applicable deductible and coinsurance.

Inlays. Inlays are covered at the same frequency as an amalgam filling. Inlays will be paid up to the same maximum allowed amount for an amalgam filling. You're responsible to pay for any amount over the maximum allowed amount, plus any applicable deductible and coinsurance.

Onlays or Permanent Crowns. Covered 1 time per 60 months. Only covered on a permanent tooth. To be covered, the tooth must have extensive loss of natural structure due to decay or fracture so that another restoration (such as a filling or inlay) cannot be used to restore the tooth. We will pay up to the

maximum allowed amount for a porcelain to noble metal crown. If you choose to have another type of crown, you're responsible to pay for the difference plus any applicable deductible and coinsurance.

Recement an Inlay, Onlay or Crown. Covered 6 months after initial placement.

Inlay, Onlay or Crown Repair. Covered 1 time per 36 months. The narrative from your treating dentist must support the procedure.

Implant Crowns. See the implant procedures description under Prosthodontic Services.

Restorative Cast Post and Core Build Up. Includes 1 post per tooth and 1 pin per surface. Covered 1 time per 60 months. Covered only if needed to retain an indirectly fabricated restoration (such as a crown) due to extensive loss of tooth structure due to decay or fracture.

Prefabricated Post and Core (in addition to crown). Covered 1 time per tooth per 60 months.

Occlusal Guards. Covered 1 time per 12 months for members age 13 through 18.

Prosthodontic Services

Dentures and Partial (removable prosthodontic services). Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing denture or partial, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted.

Bridges (fixed prosthodontic services). Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing bridge, a replacement is only covered if at least 5 years has passed and it cannot be repaired or adjusted. In order for the bridge to be covered:

- A natural healthy and sound tooth is present to service as the anterior and posterior retainer.
- There are no other missing teeth in the same arch that have been replaced with a removable partial denture.
- And none of the individual units (teeth) of the bridge has had a crown or cast restoration covered under this plan in the last 60 months.

The plan will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, the plan may cover a partial denture instead of the bridge. If you still choose to get the bridge, you will be responsible to pay the difference in cost, plus any applicable deductible and coinsurance.

Tissue Conditioning.

Reline and Rebase. Covered 1 time per 36 months as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance.

Repairs and Replacement of Broken Clasps.

Replacement of Broken Artificial Teeth. Covered as long as the appliance (denture, partial or bridge) is the permanent appliance and once 6 months has passed from the initial placement of the appliance and the narrative from the treating dentist supports the service.

Denture Adjustments.

Partial and Bridge Adjustments.

Recementation of Bridge (fixed prosthetic).

Single Tooth Implant Body, Abutment and Crown. Covered 1 time 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. It's recommended that you get a pretreatment estimate, so you fully understand the treatment and cost before having implant services done.

Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to your orthodontist about getting a pretreatment estimate for your orthodontic treatment plan, so you have an idea upfront what the treatment and costs will be. Your or your orthodontist should send it to us so we can help you understand how much is covered by your benefits.

Dentally Necessary Orthodontic Care. This plan will only cover orthodontic care that is dentally necessary — at least one of these criteria must be present:

- Spacing between adjacent teeth that interferes with your biting function
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of your mouth when you bite
- The position of your jaw or teeth impairs your ability to bite or chew
- On an objective, professional orthodontic severity index, your condition scores consistent with needing orthodontic care

What Orthodontic Care Includes. Orthodontic care may include the following types of treatment:

- Limited Treatment. A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment). This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment. A full kind of treatment that includes all radiographs, diagnostic casts and models, orthodontic appliances and office visits.
- Removable Appliance Therapy. Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy. Treatment that uses an appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth.

How We Pay for Orthodontic Care. Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of your treatment. In order for us to continue to pay for your orthodontic care, you must have continuous coverage under this policy.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your orthodontist should submit the necessary forms telling us when your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this policy ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this policy, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under this policy. We will not pay for any portion of your treatment that was given before your effective date under this policy.

What Orthodontic Care Does NOT Include. The following is not covered as part of your orthodontic treatment:

- Monthly treatment visits that are billed separately — these costs should already be included in the cost of treatment.

- Repair or replacement of lost, broken, or stolen appliances.
- Orthodontic retention or retainers that are billed separately — these costs should already be included in the cost of treatment.
- Retreatment and services given due to a relapse.
- Inpatient or outpatient hospital expenses, unless covered by the medical benefits of this policy.

Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Diabetes Equipment, Education, and Supplies

The Plan provides benefits for diabetes medication and supplies which are medically appropriate and necessary. Medication encompasses insulin, insulin pumps, and oral hypoglycemic agents. Covered supplies and equipment are limited to glucose monitors, test strips, syringes and lancets. Covered benefits also include outpatient self-management and educational services used to treat diabetes if services are provided through a program authorized by the State's Diabetes Control Project within the Bureau of Health.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

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

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

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

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

Dialysis

Please see “Therapy Services” later in this section.

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

Durable Medical Equipment and Medical Devices

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

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

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

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

Oxygen and equipment for its administration are also Covered Services.

Hearing Aids

The Plan provides benefits for wearable hearing aids for covered Members. Coverage is limited. Please see the Schedule of Benefits for limits that apply. Related items such as assistive listening devices, including but not limited to, frequency modulation systems, are not covered. A hearing aid is defined as a wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing. Coverage is also provided for bone-anchored hearing aids.

Orthotics

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

Prosthetics

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

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

- 1) Artificial limbs and accessories; With respect to members under the age of 18, coverage will also be provided for prosthetic devices suitable for recreational purposes. The Member's provider will determine the most appropriate model that meets the medical needs of the Member;
- 2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- 3) Breast prosthesis (whether internal or external) after a mastectomy, and surgical bras, as required by the Women's Health and Cancer Rights Act.
- 4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- 5) Restoration prosthesis (composite facial prosthesis)
- 6) Wigs (when needed after cancer treatment)
- 7) Cochlear Implants

Medical and Surgical Supplies

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

Blood and Blood Products

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

Blood Transfusions

Your Plan provides Benefits for blood transfusions including the cost of blood, blood plasma, and blood plasma expanders, and administrative costs of autologous blood pre-donations.

Early Childhood Intervention Services

The Plan provides benefits for early intervention services for members ages birth to 36 months of age with an identified developmental disability or delay. A referral from the child's Primary Care Physician is required.

Please refer to your Schedule of Benefits for limits that may apply.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital or freestanding Emergency facility for treatment.

Emergency Medical Condition

The sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe:

A. That the absence of immediate medical attention for an individual could reasonably be expected to result in:

1. Placing the physical or mental health of the individual or, with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy;
2. Serious impairment of a bodily function; or
3. Serious dysfunction of any organ or body part; or

B. With respect to a pregnant woman who is having contractions, that there is:

1. Inadequate time to effect a safe transfer of the woman to another hospital before delivery; or
2. A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another hospital.

Emergency Care

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 being 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. 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.

Stabilize, with respect to an Emergency Medical Condition, means: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility.

Foot Care

Benefits are provided for podiatry services, including systemic circulatory disease. Routine foot care is not covered.

Habilitative Services

Benefits are available for habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Prior authorization is not required for the first 12 visits of each new episode of care.

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

Home Health Care Services

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

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by 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)
- Medical 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 Abuse Services” section below.

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

Home Infusion Therapy

Please see “Therapy Services” later in this section.

Hospice Care

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may also 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 care giver 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.

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

Your Plan includes coverage for the following Medically Necessary human organ and tissue transplants.

Heart, heart/lung, lung, islet tissue, liver, adrenal gland, bone, cartilage, muscle, skin, tendon, heart valve, blood vessel, parathyroid, kidney cornea, allogeneic bone marrow, pancreas, and autologous bone marrow.

In this section, you will see the term Covered Transplant Procedure, which is defined below:

Covered Transplant Procedure

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

Prior Approval and Precertification

To maximize your benefits, you should call us 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, or Exclusions apply. Call the Member Service phone number on the back of your Identification Card and ask for the transplant coordinator. Even if we give a prior approval for the Covered Transplant Procedure, you or your Provider must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

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

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

Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are our covered Members, each will get benefits under their Plan.
- When the person getting the organ is our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

Coverage for the cost of testing for bone marrow donation suitability

The Plan provides coverage for laboratory fees up to \$150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements:

A. The covered member must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;

B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a;

C. At the time of the testing, the covered member must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found.

This benefit is limited to one test per lifetime.

Inborn Error of Metabolism

The Plan provides benefits for metabolic formula and special modified low-protein food products. They must be specifically manufactured for patients with diseases caused by inborn errors of metabolism. This benefit is limited to those members with diseases caused by inborn errors of metabolism.

Infant Formula

The Plan provides Benefits for amino acid-based elemental infant formula for children 2 years of age and under when a covered Provider has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other

commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. A covered Provider may be required to confirm and document ongoing medical necessity at least annually.

Benefits for amino acid-based elemental infant formula will be provided without regard to the method of delivery of the formula.

Benefits are provided when a covered Provider has diagnosed and through medical evaluation has documented one of the following conditions:

- Symptomatic allergic colitis or proctitis;
- Laboratory – or biopsy-proven allergic or eosinophilic gastroenteritis;
- A history of anaphylaxis;
- Gastroesophageal reflux disease that is nonresponsive to standard medical therapies;
- Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider;
- Cystic fibrosis; or
- Malabsorption of cow milk-based or soy milk-based infant formula.

Donor Breast Milk

Benefits include coverage for pasteurized donor breast milk provided to an eligible infant when ordered by a physician, physician assistant or advance practice registered nurse. An eligible infant is:

- A. An infant medically or physically unable to receive maternal breast milk or participate in breastfeeding, or if the infant's parent is medically or physically unable to produce sufficient quantities of breast milk for the infant.
- B. An infant that:
 - 1. was born at a birth weight of less than 1,500 grams (3.30 lbs);
 - 2. has a gastrointestinal anomaly or metabolic or digestive disorder or is recovering from intestinal surgery and the infant's digestive needs require additional support;
 - 3. is not appropriately gaining weight or growing;
 - 4. has formula intolerance and is experiencing weight loss or difficulty feeding;
 - 5. has low blood sugar;
 - 6. has congenital heart disease;
 - 7. has received or will receive an organ transplant; or
 - 8. has another serious medical condition for which donor breast milk is medically necessary.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting*.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms 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 or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.

- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

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

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

Maternity and Reproductive Health Services

Maternity Services

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

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal;
- Postpartum services that are necessary to transition a Member to a healthy and stable condition that meets the recommendations of the American College of Obstetricians and Gynecologists as outlined in the opinion entitled "Optimizing Postpartum Care" published May 2018 will be covered for up to 12 months following the end of the pregnancy; 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.

Contraceptive Benefits

The Plan provides benefits for prescription contraceptives and contraceptive supplies approved by the federal Food and Drug Administration (FDA) to prevent pregnancy, including related consultations, examinations, procedures, and medical services provided on an outpatient basis.

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants.

Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive and Well 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. The Plan will also cover elective abortions. Services will be provided without cost-sharing.

Fertility Services

Covered Services include Medically Necessary diagnostic procedures, products, and services intended to provide information about an individual's fertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. The Medical Necessity of Covered Services is based upon guidelines established by the American Society for Reproductive Medicine, the American College of Obstetrics and Gynecology, the Society for Assisted Reproductive Technology, or their respective successor organizations.

Medically Necessary Covered Services will include:

- Artificial insemination, with intrauterine insemination limited to three lifetime cycles
- Assisted hatching
- Diagnosis and diagnostic tests as described above
- Up to four completed egg retrievals per lifetime of the egg retrieval patient, provided that:

- i. Where a live donor is used in an egg retrieval, the medical costs of the donor associated with the retrieval will be covered until the donor is released from treatment by the reproductive endocrinologist; donor medical costs include without limitation physical examination, laboratory screening, psychological screening, and Prescription Drugs;
 - ii. Egg retrievals where the cost was not covered by any carrier, self-insured health plan, or governmental program will not count toward the four completed egg retrieval limit.
- Up to two lifetime cycles of any combination of fresh or frozen embryo transfer (FET), in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), or zygote intrafallopian transfer (ZIFT).

Note: No coverage for IVF, GIFT or ZIFT until all reasonable less expensive and medically appropriate treatments for Infertility have been attempted.

- Intracytoplasmic sperm injections
- Medications, including injectable infertility medications
- Ovulation induction
- Surgery, including microsurgical sperm aspiration
- Costs associated with Cryopreservation and storage of sperm, eggs and embryos for an individual who has a medical or genetic condition or who is expected to undergo treatment that may directly or indirectly cause a risk of impairment of fertility

Note: Precertification may be required. Please call the Member Services number on the back of your Identification Card.

Mental Health and Substance Abuse 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, 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 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 counselor (L.P.C),
- Licensed Pastoral Counselor or

- Any agency licensed by the state to give these services, when we have to cover them by law.

Nutritional Counseling

Benefits are provided for nutritional counseling when required for a diagnosed condition.

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. You may not be required to obtain a second opinion from a Provider that practices in the same office location as the first Provider. If the second opinion is obtained from an Out-of-Network Provider because an In-Network Provider is not available, we may not apply a Deductible, Coinsurance or Copayment for the second opinion in an amount greater than the Deductible, Coinsurance or Copayment that would apply to the same Covered Service if the Covered Service had been obtain from an In-Network Provider.

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.

Retail Health Clinic Care for limited basic health care services to Members without an appointment. 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 / Walk-In Center Services as described in “Urgent Care / Walk-In Center Services” later in this section.

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

Prescription Drugs Administered in the Office as described in the “Prescription Drugs Administered by a Medical Provider” later in this section.

Orthotics

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

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

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

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services, including head injury rehabilitation.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive and Well-Care Services

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) 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. Services related to a specific health concern, condition or injury may be separately billed as an office visit and may be subject to cost-sharing requirements as provided in the health plan.

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 (screening mammogram, diagnostic breast exam and supplemental breast exams will be covered without any cost-sharing),
 - b. Cervical cancer,
 - c. Colorectal cancer (during a colonoscopy screening, samples of tissue may be collected for closer examination, or polyps/lesions may be removed),
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.

Note: Coverage is provided for colorectal cancer screening for asymptomatic individuals at risk for colorectal cancer. Coverage also includes a colonoscopy when recommended as the colorectal cancer screening and a lesion is discovered and removed during the colonoscopy.

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:
 - 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. Contraceptives for which a therapeutic equivalent is offered at no cost share will be covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy section.”

For FDA-approved contraceptives, up to a 12-month supply is covered when dispensed or furnished by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.

Some categories and classes of contraceptives do not have Generics available and, in each of these categories, at least one Brand Drug is available at \$0 cost-sharing when you receive it from an In-Network Provider. If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent is Medically Necessary because a Generic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Drug with \$0 cost-sharing if your Provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. You or your Doctor can find the form online at https://file.anthem.com/Anthem_ABS_BrandContraceptiveCopayWaiverForm.pdf or by calling the number listed on the back of your ID Card. If Medical Necessity has been determined by your Provider, an exception will be granted and coverage of the Drug will be provided at \$0 cost sharing. Otherwise, Brand Drugs will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”
 - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to 1 (one) pump per pregnancy.
 - Gestational diabetes screening.

For additional information, please refer to the United States Preventive Services Task Force website:
www.uspreventiveservicestaskforce.org

5. Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task force including:
 - a. Counseling
 - b. Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy
 - c. Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.
6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
 - a. Aspirin
 - b. Folic acid supplement
 - c. Bowel preparations

Please note that certain age and gender and quantity limitations apply. For additional information, please refer to the United States Preventive Services Task Force website:
www.uspreventiveservicestaskforce.org

Note: A referral or authorization from your PCP is not required for gynecological exams.

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

Covered Services also include these services as required by state law:

- Prostate Specific Antigen test and digital rectal examination for men

Preventive Care for Chronic Conditions (per IRS guidelines)

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

<https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions>

The agencies will periodically review the list of preventive care services and items to determine whether additional services or items should be added or if any should be removed from the list. You will be notified if updates are incorporated into your Plan.

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

Prosthetics

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

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

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

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals. Prior authorization is not required for the first 12 visits of each new episode of care.

Please see “Therapy Services” in this section for further details.

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:

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

Bariatric Surgery / Morbid Obesity

The Plan provides benefits for the treatment of morbid obesity if you are diagnosed as morbidly obese for a minimum of five consecutive years. Benefits include surgery for an intestinal bypass, gastric bypass, laparoscopic banding or gastroplasty. Prior authorization is required. Benefits are not provided for weight loss medications.

Breast Reduction Surgery

The Plan provides benefits for medically necessary breast reduction surgery.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries 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.
- Removal of impacted wisdom teeth.

Your Plan also covers certain oral surgeries for children. Please refer to “Dental Services for Members through Age 18” for details.

Reconstructive Surgery

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

Note: 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.

Varicose Vein Surgery

Benefits are provided for medically necessary varicose vein surgery. Cosmetic surgery is not covered.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.

- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation/Adjustive therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments. Please see the "Chiropractic Services" provision earlier in this section for additional information.
- **Massage Therapy** – When services are part of an active course of treatment and the services are performed by a Covered Provider. A massage therapist is not a covered provider.
- **Acupuncture** – Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "**Prescription Drugs Administered by a Medical Provider**" for more details. Benefits are also available for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and 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). Also covers Prescription Drugs when they are administered to you as part of a Doctor's visit, home care visit or at an Outpatient Facility.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive Rehabilitation Therapy** – When Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory/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; water vapor; therapeutic use of medical gases (including carbon dioxide, helium) or Drugs (including anesthetics) in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

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

Urgent Care / Walk-In Center Services

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

Benefits for urgent care include:

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

Virtual Visits (Telemedicine / Telehealth Visits)

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

- “Medical Chat” means Covered Services accessed through our mobile app, with a Provider via text message or chat for limited medical care.
- “Telemedicine / Telehealth” means the delivery of health care or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing or secure instant messaging through our mobile app, interactive store and forward (asynchronous) technology, telemonitoring, and audio-only telephone .

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.

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

Benefits do not include the use of facsimile, texting outside of our mobile app, electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside our network, benefit precertification, or Provider to Provider discussions except as approved under “Office Visits and Doctor Services”.

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

Vision Services

Pediatric

These vision care services are covered for members until the end of the month in which they turn 19. To get In-Network benefits, you must use a Blue View Vision eye care provider. For help finding one, try “Find a Doctor” on our website, or call us at the number on your ID card. 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

Standard plastic (CR39) eyeglass lenses up to 55mm are covered, whether they are 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. 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 given 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.

- **Elective contact lenses** are ones you choose for comfort or appearance.
- **Non-elective contact lenses** are ones prescribed for certain eye conditions:
 - Keratoconus 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
 - Anisometropia of 3D or more
 - For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Note: We will not pay for non-elective contact lenses for any member who has 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. Your plan covers services for this condition when you go to a Blue View Vision eye care provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

Adult

These vision care services are covered for members age 19 and older. To get in-network benefits, use a Blue View Vision eye care provider. For help finding one, try “Find a Doctor” on our website, or call us at the number on your ID card. See the Schedule of Cost Shares and 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. An eye exam does not include a contact lens fitting fee.

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 and Well-Care” benefit.

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

Prescription Drugs Administered by a Medical Provider

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

Important Details About Prescription Drug Coverage

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

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

- Quantity, dose, and frequency of administration.
- Specific clinical criteria including, but not limited to, requirements regarding age (based on FDA labeling), 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 an appeal as outlined in the “Complaints and Appeals” section of this Booklet.

Designated Pharmacy Provider

Anthem 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, you will not have coverage for that Prescription Drug.

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

Continuity of Prescription Drugs

The Plan reserves the right to request a review of your previous insurance carrier's prescription drug prior authorization with your prescribing provider. If your provider participates in the review and requests that the prior authorization be continued, we will honor the previous insurance carrier's prior authorization for a period not to exceed 6 months beginning with your effective date of coverage with us.

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 visit, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Prescription Drug Benefits

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

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 (based on FDA labeling), test result requirements, and/or presence of a specific condition or disease.
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies).
- Step therapy requiring one Drug, Drug regimen or treatment be used prior to use of another Drug or Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated.
- Use of an Anthem Prescription Drug List (as described below).

You or your Provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of your Identification Card or check 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 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 "Complaints and Appeals and External Review Procedures" section of this Booklet.

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by A Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a 12-month supply of FDA-approved contraceptives when dispensed or furnished by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for information.
- Self-administered contraceptives, including oral contraceptive Drugs (other than emergency contraceptives), 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. Benefits are not available for emergency contraceptives (also referred to as "the morning-after pill"), such as Plan B and Ella.
- Prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications.
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- Flu Shots (including administration) these will be covered under the "Preventive Care" benefit.
- Immunizations required by the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.
- Compound ingredients within compound 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.
- At least one FDA-approved HIV prevention drug for each method of administration with no member cost share.
- Under certain circumstances, a pharmacist may be allowed to dispense an emergency supply of a chronic maintenance drug to a Member without a Prescription if the pharmacist is unable to obtain authorization to refill the Prescription from a healthcare Provider. Prescriptions obtained will be covered in the same manner as any other Prescription Drug covered under the Plan.
- Prescription Drugs used to treat infertility.

Where You Can Get Prescription Drugs

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

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

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

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.

Certain In-Network retail pharmacies can fill your prescription at the same Copayments that apply to the mail order Pharmacy. Please ask your Pharmacy if they participate in this special arrangement or call the Member Service number on your ID for a list of participating pharmacies.

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 "Complaints and Appeals" 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 "Complaints and Appeals" section of this booklet.

Maintenance Pharmacy

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.

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 a Specialty Pharmacy.

When you use the Specialty Pharmacy, a 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 Service at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which 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.

You may also obtain up to a 90-day supply of maintenance medications at certain Maine retail pharmacies. You can learn whether your pharmacy participates in the Mail Service Prescription Drug Program by calling the Member Services Department at the number on your ID Card. A list of pharmacies participating in the program is also available online at www.anthem.com.

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

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., by mouth, shots, 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 dosages, dosage forms, manufacturer, and administration methods (i.e., by 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.

Unless a Drug is being removed from the formulary due to safety concerns, we will provide 60 days written notice of an adverse change to the formulary to Members who are currently taking the Prescription Drug. An adverse change to the formulary includes the removal of a Prescription Drug from the formulary. It also includes moving the Prescription Drug to a higher cost share tier when such decision is not a result of the introduction to the market of a generic equivalent of that Prescription Drug.

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 or two business days, whichever is less, 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 with 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 and external review by an IRO. The IRO will make a coverage decisions 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.

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. As required by Maine law, one early refill for prescription eye drops may be available. We may also authorize coverage for less than a 30-day supply for purposes of synchronizing medications. 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 Service at the number on the back of your Identification Card.

In the event of a statewide state of emergency declared by the Governor of Maine, we will cover Prescription Drugs for up to a 180-day supply.

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 onto the website at www.anthem.com.

Drug Cost Share Assistance Programs

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, we will apply the assistance you receive to your Deductible and/or Out-of-Pocket Limit when the Prescription Drug is provided by an In-Network Provider. However, if your Plan is an HSA-compatible plan, the cost share assistance will only be applied to your Deductible to the extent it would not violate Treasury Guidelines.

Special Programs

Except when prohibited by federal regulations (such as H S A 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 Prescription Drugs You get at Retail or Home Delivery Pharmacies

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

You will be able to take advantage of a portion of the cost savings anticipated by Anthem from rebates on Prescription Drugs purchased by you from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by you is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum 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 decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

Charges you pay for non-Covered Services do not count toward any Deductible, Coinsurance, or Out-of-Pocket limits.

- 1) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

2) **Administrative Charges**

- a. Charges to complete claim forms,
- b. Charges to get medical records or reports,
- c. Membership, administrative, or access fees charged by Doctors or other Providers.
Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

- 3) **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speed aid devices and tracheo-esophageal voice devices approved by Anthem.

- 4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is 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,
- Holistic medicine,
- Homeopathic medicine,
- Hypnosis,
- Aroma therapy,
- Reiki therapy,
- Herbal, vitamin or dietary products or therapies,
- Naturopathy (services provided by a Doctor of Naturopathic Medicine are not covered if they would not be covered by another Provider under this plan),
- Thermography,
- 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
 - Neurofeedback / Biofeedback.
- 5) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) for all indications except as described under Autism Services in the “What’s Covered” section unless otherwise required by law.
 - 6) **Autopsies** Autopsies and post-mortem testing, except as required by law.
 - 7) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

If you are an inpatient on the date your group cancels coverage with Anthem BCBS and you have care after the date your group coverage ends and your group has replacement coverage, the replacement carrier pays primary benefits for the inpatient care provided after the effective date and this Plan pays secondary benefits. If there is no replacement carrier, this Plan pays primary benefits. Benefits under this Plan will end when you are no longer disabled, when you reach any contract maximums, when you are discharged as an inpatient and you are no longer disabled, or six months from the termination of your group contract, whichever occurs first.
 - 8) **Certain Providers** 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.
 - 9) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
 - 10) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services, except for Surprise Billing Claims as outlined in the “Surprise Billing Protection Notices” in the front of this booklet.
 - 11) **Clinical Trial Non-Covered Services** Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
 - 12) **Clinically Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com. If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with 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.
 - 13) **Complications of/ or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
 - 14) **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
 - 15) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy.

- 16) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
- 17) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- 18) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- 19) **Delivery Charges** Charges for delivery of Prescription Drugs.
- 20) **Dental Devices for Snoring** Oral appliances for snoring.
- 21) **Dental Services** Coverage is not provided for the following Dental-related services:
 - Dental care for members age 19 and older, unless covered by the medical benefits of this Plan.
 - Dental services or health care services not specifically covered under the Plan (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).
 - 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 hygiene aids.
 - Case presentations of detailed treatment plans, office visits during and after regularly schedule hours, when no other services are performed.
 - Services of anesthesiologist, unless required by law.
 - 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.
 - Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. Includes 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.
 - Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
 - Enamel microabrasion and odontoplasty.
 - Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Plan.
 - Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this Plan.
 - Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this Plan.
 - Separate services billed when they are an inherent component of another covered service.
 - Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
 - Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
 - Provisional splinting temporary procedures or interim stabilization.
 - Pulp vitality tests
 - Adjunctive diagnostic tests
 - Incomplete root canals
 - Cone beam images
 - Anatomical crown exposure
 - Temporary anchorage devices
 - Sinus augmentation.

- Oral hygiene instructions.
 - 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.
 - The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
 - For dental services received prior to the effective date of this policy or received after the coverage under this policy has ended.
 - Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
 - Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this policy.
 - Athletic mouth guards.
 - Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
 - 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.
- 22) **Dental treatment** for injuries that are a result of biting or chewing, unless the chewing or biting results from a medical or mental condition. This Exclusion does not apply to services that we must cover by law.
- 23) **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- 24) **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits based on FDA labeling.
- 25) **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- 26) **Drugs Prescribed by Providers Lacking Qualifications/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications including certifications as determined by Anthem.
- 27) **Drugs that Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.
- 28) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
- 29) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.

- 30) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
- 31) **Eye Exercises** Orthoptics and vision therapy.
- 32) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
- 33) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- 34) **Fertility Treatment** which is considered an Experimental Fertility Procedure, non-medical costs related to egg or sperm donor or surrogacy; Fertility Treatments not specified in this Booklet. Ovulation kits and sperm testing kits and supplies.
- 35) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
- a) Cleaning and soaking the feet.
 - b) Applying skin creams to care for skin tone.
 - c) Other services that are given when there is not an illness, injury or symptom involving the foot.
- 36) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting lower limbs, such as severe diabetes, devices unless stated as covered in the "What's Covered" section of this certificate.
- 37) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.
- 38) **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.
- 39) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.
- If your Group is not required to have Workers' Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
- 40) **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
- 41) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 42) **Hearing Aids** 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.
- 43) **Home Health Care**
- a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.

- b) Food, housing, homemaker services and home delivered meals.
- c) Private duty nursing.
- 44) **Hospital Services Billed Separately** Services 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.
- 45) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- 46) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- 47) **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This exclusion does not apply to “Habilitative Services” as described in the “What’s Covered” section.
- 48) **Medical Chats Not Provided through Our Mobile App**, Texting or chat services provided through a service other than our mobile app.
- 49) **Medical Equipment, Devices and Supplies**
 - a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
 - d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is your responsibility.
 - e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What’s Covered” section.
- 50) **Medicare** For which benefits are payable under Medicare Parts A, and/or B, except as required by law, as described in the section titled “Medicare” in “General Provisions.”
- 51) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 52) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 53) **Non-Approved Drugs** Drugs not approved by the FDA.
- 54) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- 55) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 56) **Nutritional or Dietary Supplements** 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.
- 57) **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it. Prescription drugs approved by the Federal Drug Administration (FDA) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.
- 58) **Oral Surgery** Extraction of teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

- 59) **Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care or Authorized Services.
- 60) **Personal Care, Convenience and Mobile/Wearable Devices**
- a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - c) Home workout or therapy equipment, including treadmills and home gyms,
 - d) Pools, whirlpools, spas, or hydrotherapy equipment,
 - e) Hypo-allergenic pillows, mattresses, or waterbeds,
 - f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, and handrails),
 - g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
- 61) **Private Duty Nursing** Private duty nursing services.
- 62) **Prosthetics** Prosthetics are not covered for the following:
- a) Cosmetic purposes (including wigs and scalp hair prosthetics);
 - b) Sports prosthesis for members 18 years of age or older.
- 63) **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
- a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
- 64) **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.
- 65) **Sanctioned or Excluded Providers** Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.
- 66) **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely.
- 67) **Services Received Outside of the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care and Emergency Ambulance.

- 68) **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 69) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 70) **Sterilization** Services to reverse an elective sterilization.
- 71) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- 72) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 73) **Travel Costs**
- Non-authorized travel related expenses: including mileage, lodging, meals and other travel related expenses, except as authorized by us or as specified as a Covered Service in this Certificate.
 - Maine Travel Assistance Program: Coverage is not provided for travel within the State of Maine, or states other than Connecticut, Massachusetts, and New Hampshire. Travel coverage is excluded for services that do not meet those defined within the Maine Travel Assistance Program, including services or care from an Out-of-Network Provider.
- 74) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 75) **Vision Services** Coverage is not provided for services incurred for or in connection with any of the items below:
- Eyeglasses lenses, frames or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.
 - For safety glasses and accompanying frames.
 - For two pairs of glasses in lieu of bifocals.
 - For plano lenses (lenses that have no refractive power).
 - Lost or broken lenses or frames, unless the member has reached their normal interval for service when seeking replacements.
 - For services or supplies not specifically listed as covered in this Booklet.
 - Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated 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.
 - Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
 - Blended lenses.
 - Oversize lenses.
 - For sunglasses.
- 76) **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.
- 77) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.
- This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss) and fasting programs.
- 78) **Wilderness or other outdoor camps and/or programs** Programs and/or outdoor camps, including but not limited to, Wilderness camps.

- 79) **Workers' Compensation** Benefits for any condition, ailment, or injury that arises out of and in the course of employment or any disability that develops because of an occupational disease. We do not provide Benefits for services or supplies, to the extent that they are obtained, either completely or partially, under any Workers' Compensation Act or similar law, or would be obtainable under these laws but for a waiver or failure to assert your rights under these laws. However, we do provide Benefits if you are entitled under the applicable workers' compensation law to waive all workers' compensation coverage, and do so before the condition, ailment, or injury occurs.

We will pay Benefits on a provisional basis for treatment of a contested work-related condition, ailment, or injury **only if all the following conditions are met:**

- You are making a claim under the Workers' Compensation Act;
- Your health care coverage is provided through an employee health plan;
- Your employer or your employer's workers' compensation insurer has filed a notice of controversy stating that your claim is being denied for work-relatedness;
- The Workers' Compensation Board has not made a determination on your claim;
- Your employer has made no payment on or settlement of your claim.

Even though you may be submitting a claim under the Workers' Compensation Act, you should also submit your claims under this plan.

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

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

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial for Non-Covered Services** Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
4. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent 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.
5. **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
6. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
7. **Delivery Charges** Charges for delivery of Prescription Drugs.
8. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy

in the office as described in the “**Prescription Drugs Administered by a Medical Provider**” section, or Drugs covered under the “Medical and Surgical Supplies” benefit – they are Covered Services.

9. **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 the “Prescription Drug List” in the section “Prescription Drug Benefits at a Retail or Home Delivery (Mail Order) Pharmacy” for details on requesting an exception.
10. **Drugs Over Quantity or Age Limits** Drugs which are over the quantity limits set by the Plan, or which are over any age limits based on FDA labeling.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
13. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the “What’s Covered” section.
14. **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.
15. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
16. **Growth Hormone Treatment** Any treatment, device, drug, or 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.
17. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
18. **Fluoride Treatments** Topical and oral fluoride treatments. While these services are not covered under the prescription drug benefit, they may be covered under the dental service benefit. Please see that section for further details.
19. **Items Covered as Durable Medical Equipment (DME)** 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 (DME), Medical Devices, and Supplies” benefit. Please see that section for details.
20. **Items Covered Under the “Allergy Services” Benefit** 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.
21. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
22. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
23. **Non-approved Drugs** Drugs not approved by the FDA.
24. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

25. **Nutritional or Dietary Supplements** 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.
26. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
Prescription drugs approved by the Federal Drug Administration (FDA) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.
27. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
28. **Over-the-Counter Items** Drugs, devices and products, or Prescription Legend Drugs with over-the-counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over-the-counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Legend 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. For additional information, please refer to the United States Preventive Services Task Force website: www.uspreventiveservicestaskforce.org
29. **Sanctioned or Excluded Providers** Any Drug, Drug regiment, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
30. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
31. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
32. **Weight Loss Drugs** Any Drug mainly used for weight loss.

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. Please remember that this Plan will not provide benefits for services from Out-of-Network Providers unless the claim is for Emergency Care, Urgent Care, or for services approved in advance by Anthem as an Authorized Service.

If the insured is covered as a dependent child, and if we receive a request from a parent of the insured, we will provide that parent with:

1. Payment or denial of claim. An explanation of the payment or denial of any claim filed on behalf of the insured, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent;

2. Change in terms and conditions. An explanation of any proposed change in the terms and conditions of the policy; or

3. Notice of lapse. Reasonable notice that the policy may lapse, but only if the parent has provided us with the address at which the parent may be notified.

In addition, any parent who is able to provide the information necessary for us to process a claim must be permitted to authorize the filing of any claims under the policy.

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 Programs" 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 Health Care; 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 Copayment or Coinsurance.

Generally, services received from an Out-of-Network Provider under this product are not covered except for Emergency Care, or when allowed as a result of a referral by us. 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 Service 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. If you use an Out-of-Network Provider, your entire claim will be denied except for Emergency or Urgent Care, unless the services are approved by us as a result of a Referral.

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

1. An amount based on our network or non-network provider fee schedule/rate (as required by law), 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 Anthem, 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 Anthem's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing 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 unless we have authorized Covered Services from a Non-Network Provider due to Provider Network inadequacies. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Member Service for help in finding an In-Network Provider or visit our website at www.anthem.com.

Member Service 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 Service 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).

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 an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

Authorized Services

In some circumstances, such as where there is no 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 a

Covered Service so that you are responsible for In-Network cost share amounts, you will not 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 Service for Authorized Services information or to request authorization.

Referrals

Your group health plan provides extensive benefits when health care services are provided or coordinated by your primary care physician. You will receive most of your health care services from your primary care physician. Your Primary Care Physician may refer You to a Specialist. Specialists are Providers who practice in specialty areas such as neurology, surgery, and others. With the prior authorization of your Primary Care Physician, You can obtain care from Network Specialists. You do not need a Referral or approval from your PCP to see an Obstetrician/Gynecologist (OB/GYN). You may receive Covered Services from a Network Provider with a referral from a Direct Primary Care Provider (DPCP). A referral from your primary care physician is not a guarantee of coverage for those services. The service must also be covered within the terms of this contract. Thus, regardless of medical necessity, no benefits will be provided for care that is not a covered service, even if performed by your PCP or authorized as a Referral Service. You may call a Member Service Representative at the number on your ID card to determine if the service is a covered service.

If your primary care physician authorizes a referral to a Provider, make sure you understand:

- The name of the Provider to whom you are being referred.
- The period of time, the number of visits and services for which care is authorized.
- Who is to make the appointment(s) with that Provider - you or your primary care physician's office staff.

You are responsible for confirming that the Provider you have been referred to see is a Network Provider for this Plan. You will need to discuss additional care recommended by the referring Provider with your primary care physician, if the care exceeds the initial referral for services.

If your referred Provider recommends you to another Provider, **you must contact your primary care physician prior to any treatment** so he or she can determine if that care will be authorized. Only your primary care physician can authorize care with another Provider.

If your primary care physician authorizes these services, benefits will be provided according to the terms of this contract. Care that is not authorized by your primary care physician is not covered, unless otherwise stated in this contract.

Referrals for mental health and substance abuse treatment services must be obtained through our mental health care manager. You do not need a referral from your primary care physician. Please refer to the "Utilization Management" section of this certificate for details.

Note: If your primary care physician determines you do not need a referral and you disagree, you have the right to appeal the decision, as outlined in this booklet.

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 emergency services, or other services authorized by us

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

Notice of Claim & Proof of Loss

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

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information 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. 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.

Claims will be paid within 30 days of the date we get the completed claim and proof of loss.

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

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. Where permitted by applicable law, 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.

Anthem covers only limited healthcare services received outside of the Anthem Service Area. For example, Emergency or Urgent Care obtained outside the Anthem Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Anthem.

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 nonparticipating 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. The Plan only covers Emergency, including ambulance, and Urgent Care outside of 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.

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.

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

Coordination of Benefits

All benefits of the contract are subject to coordination of benefits (COB). COB is a formula that determines how benefits are paid to members covered by more than one contract. It helps keep down the cost of health coverage by ensuring that the total benefits you receive from all contracts do not exceed the cost of covered services.

COB sets the payment responsibilities for any contract that covers you, such as:

- Group, individual (also known as non-group), self-insured plans, franchise, or blanket insurance, including coverage through a school or other educational institution but excluding school accident type coverage;
- Group practice, individual practice, and other prepaid group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
- Other insurance that provides medical benefits.

The contract with primary responsibility provides full benefits for covered services as if there were no other coverage. The contract with secondary responsibility may provide benefits for covered services in addition to those of the primary contract. When there are more than two contracts covering the person, the contract may be primary to one or more contracts, and may be secondary to another contract or contracts. All benefits are limited to the contract maximums or to the maximum allowance for the services you receive.

The following are non-Allowable expenses:

- 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.

When you have duplicate coverage:

- If the other contract does not contain a COB clause or does not allow coordination of benefits with this contract, the benefits of that contract will be primary;
 - If both contracts contain a COB clause allowing the coordination of benefits with this contract, we will determine benefit payments by using the first of the following rules that applies:
1. **Pediatric Dental Coordination of Benefits (COB).** These pediatric dental COB provisions are applicable to only the pediatric dental benefits found in the part titled What's Covered in the section Dental Services. If pediatric dental Essential Health Benefits are included as part of the medical plan, the medical plan will be primary coverage and any standalone dental plan will be secondary. If the member has two medical plans, each offering pediatric dental Essential Health Benefit coverage for spouse and family, the Order of Benefits Determinations rules below apply.
 2. **Non-Dependent/Dependent** The benefits of the contract that covers you as an employee or subscriber will be determined before the benefits of the contract that covers you as a dependent are determined.
 3. **Dependent Children (Parents Not Legally Separated or Divorced)** For claims on covered dependent children, the contract of the parent whose birthday occurs first in the year will be primary. If both parents have the same birthday, the contract that has covered one parent longer will be primary over the contract that has covered the other parent for a shorter period. If the other contract does not include the rule described immediately above, but instead has a rule based on

the gender of the parent, and as a result the contracts do not agree on the order of benefits, the rule in this contract will determine the order of benefits.

4. **Dependent Children (Parents Legally Separated or Divorced)** In the case of legal separation or divorce, the coverage of the parent with custody will be primary. If the parent with custody has remarried, coverage of the parent's spouse will be secondary, and the coverage of the parent without custody will be last. Whenever a court decree specifies the parent who is financially responsible for the dependent's health care expenses, the coverage of that parent's contract will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of benefits is determined by following rule two.
5. **Active/Inactive Employee** The benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee's dependent). If the other coverage does not include this provision, and as a result, the contracts do not agree on the order of benefits, rule six applies.
6. **Continuation of Coverage** If a person whose coverage is provided under the right of continuation pursuant to a federal or state law is also covered by another contract, the benefits of the contract covering the person as an employee or subscriber, or as the dependent of an employee or subscriber, will be primary. The benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule six applies.
7. **Longer/Shorter Length of Coverage** If none of the rules above determines the order of benefits, the benefits of the contract that has covered the employee or subscriber longer will be determined before those of the contract that has covered the person for a shorter period.

We reserve the right to:

- Take any action needed to carry out the terms of this section;
- Exchange information with an insurance company or other party;
- Recover the Plan's excess payment from another party or reimburse another party for its excess payment; and
- Take these actions when we decide they're necessary without notifying the covered persons.

Credit toward deductible When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan.

Subrogation and Reimbursement

Subrogation: Payments Resulting from Claim or Legal Action

When another party may have caused or may be responsible for your injury or illness, you may be entitled to payment from a claim or legal action against that party.

When we provide health care benefits for treatment of your injury or illness, we have the right to recover, from any such payment (whether by judgment, suit, compromise, settlement or otherwise) up to the total benefit we paid, on a just and equitable basis. The process of recovering these expenses is called subrogation.

We also have subrogation rights against your own insurance, including medical payments, uninsured, and underinsured motorist provisions in your auto insurance policy.

Subrogation applies whether any of the payment or settlement is allocated for medical expenses.

If the services related to your illness or injury are covered by a capitation fee, we are entitled to the reasonable cash value of the services.

By accepting plan coverage you agree:

- Your signed application for coverage is your approval and authorization of our right of subrogation on a just and equitable basis;
- To notify us of any event which could result in legal action, a claim against a third party, or a claim against your own insurance;
- To notify us of any payments you receive as a result of legal action, a claim against a third party, or a claim against your own insurance;
- To immediately notify us if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a legal action. Any payments you receive must not be dissipated or disbursed until such time as we have been repaid in accordance with these provisions.
- To cooperate with us in exercising our right of subrogation by providing all information requested;
- To sign documents we deem necessary to protect our rights; and
- To do nothing to interfere with our subrogation rights.

If you do not comply with the above, you may be responsible for expenses we incur in enforcing our subrogation rights.

Complaints and Appeals Process and External Review Procedures

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 Service by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Complaint / Appeal, which is defined as follows:

Complaints and Appeals

Complaints

Our Member Service Representatives are ready to help Members resolve complaints about claims processing, benefit choices, enrollment, or health care given to you by your Provider. A Member Service Representative may need to send your complaint to another area for response. The staff that gets the Member complaint will review and quickly give a finding to the Member on the complaint. Anthem will make a good faith effort to get all information quickly. Your Provider may ask by phone, fax or in writing for us to reconsider an adverse determination within one working day after we get the request. The review will be done by the person who made the adverse determination or by a peer if the first person cannot be on hand within one working day.

For first Utilization Review findings, Anthem will make the decision and will let the Covered Person and their Provider know the result within 2 working days after getting all needed information on a proposed hospital stay, treatment or service that calls for a review decision.

If more information is needed, a final decision will be made within thirty (30) days after the added information is received. If your complaint is not resolved to your satisfaction, you may seek help through the Appeal process outlined below. Enrollees may begin a first level Appeal at any time.

Complaints Requiring Immediate Intervention

If you are not happy with a finding on a service, we will work with the health care provider to answer quickly to the concern. This will happen before the need for services, when possible, or within 48 hours after receiving all necessary information.

Concurrent review decisions.

Anthem will make the decision within one working day after getting all needed information.

In the case of a decision to approve a longer stay or more services, Anthem notifies the Member and the Provider rendering the service within one working day. The written notice will include the number of added days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, Anthem notifies the Member and the Provider rendering the service within one working day. The service will continue without liability to the Member until the Member has been told of the finding.

Expedited Appeals. Anthem has a written process for the expedited review of an adverse determination involving a situation where the time frame of the standard review procedures would seriously threaten the life or health of a Member or would risk the Member's ability to get back maximum function. An expedited appeal will be available to, and may be requested by, the Member or the Provider acting for the Member.

Expedited appeals will be reviewed by a clinical peer or peers. The clinical peer/s will not have been part of the first adverse determination.

Anthem will provide expedited review to all requests for a hospital stay, availability of care, continued stay or health care service for a Member who has received emergency services but has not been discharged from a facility.

In an expedited review, all needed information, including Anthem finding, will be shared between Anthem and the Member or the Provider acting for the covered person by telephone, facsimile, electronic means or the quickest method available.

In an expedited review, Anthem will make a decision and notify the Member and the Provider acting for the Member by phone as quickly as the Member's medical condition requires, but not more than 72 hours after the review is begun. If the expedited review is a concurrent review decision of emergency services or of an initially authorized hospital stay or course of treatment, the service will be continued without liability to the Member until the Member has been notified of the finding.

If the first notice was not in writing, Anthem will confirm its finding about the expedited review in writing within 2 working days of providing notice of that finding.

Appeals

Level One Appeal Process

You or your authorized representative, if not satisfied with the first decision or the finding on a complaint, may Appeal the decision to the Anthem Appeals Department. An Appeal may be done orally or in writing and must include specific reasons why you or your representative do not agree with the finding. Appeal of a finding must be sent to within one-hundred-eighty (180) calendar days of the date the finding was made, unless there are special circumstances. We have the right to review the reason for the delay and find out whether they warrant acceptance of the Level One Appeal past the 180-day time frame.

On Appeal, the file will be reviewed. Appeals will be reviewed by a clinical peer or peers who have not been involved with a prior finding. In an appeal of an adverse health care treatment decision, you have the right to review the claim file. More information may be submitted by or for the Member, any treating physician, or Anthem as part of the internal process. A finding will be made within thirty (30) days after we receive the request for an Appeal.

The decision will include:

- The names, titles and information that qualifies the person or persons evaluating the appeal;
- A statement of the reviewers' understanding of the reason for the Covered Person's request for an Appeal;
- The reviewers' finding in clear terms and the reason in enough detail for the Covered Person to respond to the health carrier's finding;
- A reference to the evidence or information used as the basis for the finding, including the clinical review materials used to make the decision. The finding shall include instructions for requesting copies of any referenced evidence, documents or clinical review information not already provided to the Member. Where a Member had already sent in a written request for the review criteria used by Anthem in giving its first Adverse Determination, the finding shall include copies of any additional clinical review criteria used in arriving at the decision.
- The notice must advise of any additional appeal rights, and the process and time limit for exercising those rights. Notice of external review rights must be provided to the Enrollee and a description of the process for sending in a written request for second level grievance review.

When the finding is made, if the Member, or Member representative, does not agree with the finding, they may submit a voluntary second level Appeal to Anthem, request an external review, file a complaint with

the Bureau of Insurance and/or bring legal action against Anthem. The Superintendent of Insurance may be contacted toll-free at 1-800-300-5000.

If you choose to request a voluntary second level Appeal, you may meet with the review panel in person, or at Anthem's expense by conference call, video conferencing or other appropriate technology to present your concerns with our adverse determination.

Level Two Appeal Process

On a Level Two Appeal, the entire record will be reviewed. Appeals of a clinical nature will be reviewed by an appropriate peer or peers who have not been involved with the prior finding. Additional information may be sent in by or for the Member, any treating Physician, or Anthem BCBS. You or your representative may meet with the review panel. If you do not request to meet in person, the decision for second level grievance reviews will be made within 30 calendar days. If you do request to appear in person, the review will be done within forty-five (45) days after we receive the Member's Level Two Appeal. A written decision will be sent to the Member within five (5) working days of the review. Once a final decision has been made by the Second Level Appeal panel, the Member may then ask for an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem BCBS.

In any Appeal under this procedure in which a professional medical opinion about a health condition is an issue, you may have the right to an independent second opinion, of a provider of the same specialty, paid for by the plan.

Upon the request of a Member, Anthem shall provide to the Member all information that was used for that finding that is not confidential or privileged.

A Member has the right to:

- Attend the second level review;
- State his or her case to the review panel;
- Submit added material both before and at the review meeting;
- Ask questions of any employee in the meeting; and
- Be assisted or represented by a person of his or her choice.

If, after our denial, 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 decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If 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.

External Review Process

Your representative is a person who has your written consent to represent you in an external review; a person authorized by law to give consent to request an external review for you; or a family member or your treating physician when you are unable to provide consent to request an external review.

If you, or your representative, do not agree with the outcome of the Level One or Voluntary Level Two Appeal on an Adverse Health Care Treatment Decision by Anthem, you may make a written request for external review to the Bureau of Insurance. A health care treatment decision involves issues of medical necessity and findings regarding experimental or investigational services. An adverse health care treatment decision is a decision made by us or on our behalf denying payment. The request must be made within 12 months of the date the Member has received the final adverse health care treatment decision of the Level One or Voluntary Level Two Appeal panel.

You or your representative may not request an external review until you have completed Level One of the internal Appeals process unless:

- Anthem BCBS did not make a decision on an Appeal within the time period required or has failed to follow all the requirements of the appeal process as state and federal law require, or the Member has asked for an expedited external review at the same time as applying for an expedited internal appeal;
- Anthem BCBS and you both agree to bypass the internal Appeals process;
- The life or health of the Member is at risk;
- The Member has died; or
- The adverse health care treatment decision to be reviewed concerns an admission, availability of care, a continued stay or health care services when the claimant has received emergency services but has not been discharged from the facility that provided the emergency services.

The Bureau of Insurance will oversee the external review process. Except as stated below, a written finding must be made by the independent review organization within thirty (30) days after receipt of a completed request for external review from the Bureau of Insurance.

Expedited External Review.

An external review finding must be made as quickly as a Member's medical condition requires but no more than 72 hours after the completed request for external review is received if the 30-day time frame above would risk the life or health of the Member or would put the Member's ability to get back maximum function at risk.

An external review finding is binding on Anthem. You, or your representative, may not file a request for a second external review involving the same adverse health care treatment decision for which you have already received an external review decision.

The Grievance should be sent to the following address:

For medical and Prescription Drug or Pharmacy Issues:

Anthem BCBS ME
Attention Appeals
PO Box 218
North Haven, CT 06473-0218

For Dental Issues

Anthem Blue Cross and Blue Shield
Attn: Grievance Department
PO Box 1122
Minneapolis, MN 55440-1122

For Vision Issues

Blue View Vision
Attn: Grievance Department
P.O. Box 9304
Minneapolis, MN 55440-9304

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within three years of our final decision on the claim or other request for benefits. If we decide an appeal is untimely, our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust our internal appeals process before filing a lawsuit or other legal action of any kind against us. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

Prescription Drug List Exceptions

Please refer to the "Prescription Drug List" section in the "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 see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee of the Group, and;
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and perform the duties of your principal occupation for the Group;
- Reside or work in the Service Area.

Dependents

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

- The Subscriber's spouse. For information on spousal eligibility please contact the Group.
- The Subscriber's Domestic Partner.

For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.

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

- For those Dependents who cannot work to support themselves due to a physical, mental, intellectual or developmental impairment. We must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the Dependent reaching the limiting age. You must give the proof at no cost to us.

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

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

Types of Coverage

Your Group offers the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options are as follows:

- Subscriber only (also referred to as single coverage);
- Subscriber and spouse or Domestic Partner;
- Subscriber and one child;
- Subscriber and children;
- Subscriber and family.

When You Can Enroll

Initial Enrollment

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

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

Open Enrollment

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

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- 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.).

Medicaid and Children's Health Insurance Program Special Enrollment

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

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

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

Late Enrollees

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

Members Covered Under the Group's Prior Plan

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

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth of a child, to continue coverage beyond the initial 31 days, you must submit an application / change form to the Group within 31 days to add the newborn to your Plan.

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

Adopted Children

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

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event.

Adding a Child due to Award of Legal Custody or Guardianship

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

Qualified Medical Child Support Order

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

Updating Coverage and/or Removing Dependents

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

- Changes in address;
- Marriage, divorce, or change in domestic partner status;
- 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;
- 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, age, 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" 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 Group 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 Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or 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.
- 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 Group. 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.
- If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area.

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

Notice of Cancellation of the Group Contract If Group coverage is canceled as a result of the responsible individual's cognitive impairment or functional incapacity, the Group or subgroup may be eligible for reinstatement. The responsible individual is the person who is responsible for making premium payments on behalf of a Group or subgroup.

The right to reinstate Group coverage has the same limitations and requirements as listed in the "Notice of Cancellation of the Member's Contract" and "Right to Reinstatement" provisions as described below.

This does not limit our right to cancel Group or subgroup coverage on the grounds that the employer is no longer in business, even if the end of the business results from the employer's cognitive impairment or functional incapacity.

Notice of Cancellation of the Member's Contract If your coverage is canceled for non-payment of Subscription Charges or other lapse or default, we will send you a notice of cancellation at least 10 days prior to the cancellation. We will offer you the opportunity to reinstate your coverage as set forth below. The charges will be the same amount they would have been if the Contract had remained in force. Please refer to the Group Continuation Coverage section, below, for information regarding cancellation of COBRA coverage.

You have the right to designate another person to receive notice of cancellation of this Contract for non-payment of charges or other lapse or default. We will send the notice to you and the person you designate at the last addresses you provided to us. You also have the right to change the person you designate if you wish. In order to designate a person to receive this notice or to change a designation, you must fill out a Third-Party Notice Request Form. You can obtain this form from your Group or by contacting us. Within 10 days after a request by a member, a Third Party Notice Request Form will be mailed to the member.

Right to Reinstatement Within 90 days after cancellation due to nonpayment of premium, a policyholder, a person authorized to act on behalf of the policyholder or a dependent of the policyholder covered under a health insurance policy or certificate may request reinstatement on the basis that the loss of coverage was a result of the policyholder's cognitive impairment or functional incapacity.

If you request reinstatement, we may require a Physician examination at your own expense or request medical records that confirm you suffered from cognitive impairment or functional incapacity at the time of cancellation. If we accept the proof, we will reinstate your coverage without a break in coverage. We will reinstate the same coverage you had before cancellation or the coverage you would have been entitled to if the Contract had not been canceled, subject to the same terms, conditions, exclusions, and limitations. Before we can reinstate your Contract, you must pay the amount due from the date of cancellation through the month in which we bill you. Payment must be made with 15 days after the date you are billed. The charges will be the same amount they would have been if the Contract had remained in force.

If we deny your request for reinstatement, we will send you a Notice of Denial. You have the right to an Appeal, or to request a hearing before the Superintendent of Insurance within 30 days after the date you receive the Notice of Denial from us.

Removal of Members

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

Continuation of Coverage Under Federal Law (COBRA)

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

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

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

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

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

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

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and

that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

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

Notification Requirements

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

You Must Give Notice of Some Qualifying Events

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

Electing COBRA Continuation Coverage

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

Disability extension of 18-month period of continuation coverage

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

Trade Adjustment Act Eligible Individual

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

When COBRA Coverage Ends

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

- A covered individual reaches the end of the maximum coverage period;
- A covered individual fails to pay a required Premium on time;
- A covered individual becomes covered under any other group health plan after electing COBRA;
- A covered individual becomes entitled to Medicare after electing COBRA; or
- The Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

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

If You Have Questions

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

Continuation of Coverage under Maine Law

A member or employee is eligible for continued coverage only if the member or employee's group insurance coverage terminated for one of the following reasons:

- The member or employee was temporarily laid off;
- The member or employee was permanently laid off and is eligible for premium assistance in accordance with federal law;
- The member or employee lost employment because of an injury or disease that the employee claims to be compensable under Workers' Compensation.

The member or employee has 31 days from the termination of coverage in which to elect and make the initial premium payment. Coverage will be provided at the same level in force immediately before termination. The member or employee will be responsible for premium payments.

Continuation of Coverage Due To Military Service

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

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

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

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

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

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

Maximum Period of Coverage During a Military Leave

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

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
 - The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - 14 days after completing military service for leaves of 31 to 180 days,
 - 90 days after completing military service for leaves of more than 180 days; or
2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within 30 days of the end of military service:

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

1. Two years; or

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

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

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

Family and Medical Leave Act of 1993

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

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

Benefits After Termination Of Coverage

If you are an inpatient on the date your group cancels coverage with Anthem BCBS and you have care after the date your group coverage ends and your group has replacement coverage, the replacement carrier pays primary benefits for the inpatient care provided after the effective date and this Plan pays secondary benefits. If there is no replacement carrier, this Plan pays primary benefits. Benefits under this Plan will end when you are no longer disabled, when you reach any contract maximums, when you are discharged as an inpatient and you are no longer disabled, or six months from the termination of your group contract, whichever occurs first.

Any benefits available under this section are subject to all the other terms and conditions of this Plan.

If you are Totally Disabled on the Group's termination date, and you are not eligible for regular coverage under another similar health plan, benefits will continue for treatment of the disabling condition(s). Benefits will continue until the earliest of:

1. The date you cease to be Totally Disabled;
2. The end of a period of 12 months in a row that follows the Group termination date;
3. The date you become eligible for regular coverage under another health plan; or
4. The payment of any benefit maximum.

Benefits will be limited to coverage for treatment of the condition or conditions causing Total Disability and in no event will include benefits for any dental condition.

General Provisions

Assignment of Benefits

You may assign benefits provided for covered services to the provider of the care. Contact your provider to complete the necessary forms.

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 Group or us.

Comparable Health Care Services

Prices for the same medical services can vary greatly. Your health plan may offer an incentive to shop for low-cost, high-quality health care services, including Comparable Health Care Services, from participating providers. "Comparable Health Care Service" means certain non-emergency, outpatient health care services in the following categories:

- Physical and occupational therapy services;
- Radiology and imaging services
- Laboratory services; and
- Infusion therapy services

If offered with your plan, incentives may be provided through the SmartShopper program and may include, but are not limited to, cash payments, gift cards or credits or reductions of premiums, copayments or deductibles. The SmartShopper program includes incentives for Comparable Health Care Services, but incentive amounts and other eligible services eligible to earn an incentive are subject to change at any time.

If the SmartShopper program is offered as part of your health plan and your provider recommends a Covered Service that is a Comparable Health Care Service or other medical test, service or procedure that is included in the SmartShopper program and eligible for an incentive, in order to earn an incentive you must:

1. Register with SmartShopper by phone 1-866-488-5441 or online at www.smartshopper.com;
2. Call or visit SmartShopper online to search for a location in your area that is eligible for an incentive before receiving the medical test, service or procedure;
3. Have the test, service or procedure at one of the locations on the SmartShopper list.

After you receive a test, service, or procedure at the cost-effective location identified by SmartShopper you should receive your incentive payment in the mail within 60 days after the claim is paid.

Please call the toll-free number on your ID Card, or visit our website www.anthem.com or www.smartshopper.com for additional information, including information on eligible services and incentive amounts.

Confidentiality and Release of Information

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

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

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this 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 Group 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 Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Health Plans of Maine, Inc. 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 Maine. 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 Group, 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 Anthem Health Plans of Maine, Inc. and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Group for any of Anthem's obligations to the Group 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 Contract is issued will apply unless otherwise stated herein.

This Booklet, the Group Contract, the Group application, any riders, endorsements or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the Group and any and all statements made to the Group 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.

The statements you make on your application for coverage with us are representations and not warranties.

Examination of Insured

To ensure that all claims are valid, we may require the Member to have a physical or mental examination at our expense. We reserve the right to request an autopsy at our expense.

Form or Content of Booklet

No statement made by the application for insurance shall void the insurance or reduce benefits unless contained in the written application signed by the applicant. No agent or employee of ours is authorized to change the form or content of this Booklet or to waive any of its provisions. No change in the policy shall be valid unless approved by an officer of Anthem and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and 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.

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

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

Determining Primacy Between Medicare and this Plan – We will be the primary payer for persons age 65 and older with Medicare coverage if the Subscriber is actively working for an employer who is providing the Subscriber's health insurance and the employer has 20 or more employees. Medicare will be the primary payer for persons age 65 and older with Medicare coverage if the Subscriber is not actively working and the member is enrolled in Medicare. Medicare will be the primary payer for persons with Medicare age 65 and older if the employer has less than 20 employees and the member is enrolled in Medicare.

This Plan will be the primary payer for persons under age 65 with Medicare coverage when Medicare coverage is due to disability if the member is actively working for an employer who is providing the

member's health coverage and the employer has 100 or more employees. Medicare will be the primary payer for persons enrolled with Medicare due to disability if the member is not actively working or the employer has less than 100 employees.

This Plan will be the primary payer for persons under age 65 with Medicare coverage when Medicare coverage is due to End Stage Renal Disease (ESRD), for the first 30 months from the **entitlement to or eligibility for** Medicare (whether or not Medicare is taken at that time). After 30 months, Medicare will become the primary payer if Medicare is in effect (30-month coordination period).

When a Member becomes eligible for Medicare due to a second entitlement (such as age), we remain primary, if we were primary at the point when the second entitlement became effective, for the duration of 30 months after the Medicare entitlement or eligibility due to ESRD. If Medicare was primary at the point of the second entitlement, then Medicare remains primary. There will be no 30-month coordination period for ESRD.

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. For the purposes of the calculation of benefits, if you have not enrolled in Medicare Part B when you are eligible, we will calculate benefits as if you had enrolled. **You should enroll in Medicare Part B as soon as possible to avoid potential liability.**

You may contact the Maine Bureau of insurance or the Consumers for Affordable Health Care for assistance in understanding coordination of benefits with Medicare Part B under your contract.

- Department of Financial Regulation, Bureau of Insurance
#34 State House Station
Augusta, ME 04333-0034
Tel: 1-800-300-5000
Insurance.PFR@maine.gov
<https://www.maine.gov/pfr/insurance/home>
- Consumers for Affordable Health Care
PO Box 2490
Augusta, ME 04338-2490
Consumer Assistance Helpline: Tel 1-800-965-7476
consumerhealth@mainecahc.org
www.mainecahc.org

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 Group 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 Group Contract, or by mutual agreement between the Group 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 Group about the change. Notice of plan modifications, which are not reflected in the most recently provided Summary of Benefits and Coverage ("SBC"), will be provided to members to less than 60 days prior to the effective date of 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 may 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 In-Network Providers to us under the Program(s).

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 Group Contract, we have the authority, at our option, 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 tools, 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 includes, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as 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 (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing eligibility data to us in a timely manner. If the Group 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.

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have, to the fullest extent permitted under applicable law, discretion to determine the administration of your benefits. Our determination shall be binding, subject to any rights of complaint and/or appeal provided under the Plan or under applicable law. This may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowed Amount. However, you may utilize all applicable complaint and appeals procedures.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the, policies, and procedures with regard to the interpretation and

administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and comply with state and federal laws. A specific limitation or exclusion will override more general benefit language.

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 consistent with state law. 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 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 Group 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 Group has selected one of these options to make available to all employees, 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 Group 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 Service 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 Service at the number on the back of your Identification Card.

Accidental Injury

Treatment of an accidental bodily injury sustained by the Member that is the direct cause of the condition for which Benefits are provided and that occurs while the insurance is in force.

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.

Applied Behavior Analysis

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

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 "Claims Payment" section as well as the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details.

Autism Spectrum Disorder

Any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

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 Group's effective or renewal date and lasts for 12 months. (See your Group 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 the 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 Group Contract with your Employer, and is also subject to the terms of the Group Contract.

Brand Name Drugs

Prescription Drugs that we classify as Brand Drugs or our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Peer

“Clinical peer” means a physician or other licensed health care practitioner who holds a nonrestricted license in a state in the U.S., is board certified in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure, or treatment that the practitioner approves or denies on behalf of the carrier.

Coinsurance

The percentage of the Maximum Allowed Amount that you pay for some Covered Services.

Consolidated Appropriations Act of 2021

Please refer to the “Surprise Billing Protection Notices” at the front of this booklet for details.

Controlled Substance

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

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services. See the Schedule of Benefits for details. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the maximum allowed amount.

Cost Share (Cost Sharing)

The amount which the Member is required to pay for Covered Services. Where applicable, Cost Share can be in the form of Copayments, Coinsurance and/or Deductibles.

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 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 Of Coverage.”

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.

Cryopreservation

The freezing of embryos in liquid nitrogen until such time as required for a frozen embryo transfer, or the freezing of eggs and sperm.

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.

Dentally Necessary Orthodontic Care

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. See the ‘Dentally Necessary Orthodontic Care’ benefit description in the “What’s Covered” section of this booklet for more information.

Dependent

A member of the Subscriber’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 has executed a Designed Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Direct Primary Care Provider

Direct primary care provider" means an individual who is a licensed physician or osteopathic physician or other advanced health care practitioner who is non-Plan Provider, who is authorized to engage in independent medical practice in Maine, who is qualified to provide primary care services and who chooses to practice direct primary care by entering into a direct primary care service agreement with patients. The term includes, but is not limited to, an individual primary care provider or a group of primary care providers.

Please note: A referral can be made by a Direct Primary Care Provider who is not included in the Plan's provider network, subject to confirmation of the Direct Primary Care Provider's relationship with the Member.

Disability

"Partial Disability" or "Partially Disabled" means that as a result of an injury or sickness, you are unable to perform one or more, but not all, of the material and substantial duties of employment or occupation; or in relation to a percentage of time worked, to a specified number of hours worked, or to compensation earned.

"Total Disability" or "Totally Disabled" means that as a result of an injury or sickness, you are unable to perform any occupation or business for which you are reasonably suited by your education, training, or experience. This also means that you are not, in fact, engaged in any occupation or business for wage or profit. It includes conditions where you are confined to a Hospital or are completely incapacitated and unable to perform normal activities of daily living. We may require your Physician to send us proof of your condition.

Doctor

See the definition of "Physician."

Domestic Partner

One of 2 unmarried adults who are domiciled together under long-term arrangements that evidence a commitment to remain responsible indefinitely for each other's welfare.

Early Childhood Intervention Services

Services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act.

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

The sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given,

that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe:

- A. That the absence of immediate medical attention for an individual could reasonably be expected to result in:
 - 1. Placing the physical or mental health of the individual or, with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy;
 - 2. Serious impairment of a bodily function; or
 - 3. Serious dysfunction of any organ or body part; or
- B. With respect to a pregnant woman who is having contractions, that there is:
 - 1. Inadequate time to effect a safe transfer of the woman to another Hospital before delivery; or
 - 2. A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another Hospital.

Emergency Care

Please see the "What's Covered" section.

Emergency Service

A health care item or service furnished or required to evaluate and treat an Emergency Medical Condition that is provided in an Emergency Facility or setting.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental Fertility Procedure

A procedure for which the published medical evidence is not sufficient for the American Society for Reproductive Medicine, its successor organization or a comparable organization to regard the procedure as established medical practice.

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 Anthem determines to be Experimental or Investigational.

Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

- (a) The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:
 - (i) cannot be legally marketed in the United States without the final approval of the Food and Drug Administration ("FDA") or any other state or federal regulatory agency and such final approval has not been granted; or
 - (ii) has been determined by the FDA to be contraindicated for the specific use; or
 - (iii) is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic,

- device, diagnostic, product, equipment, procedure, treatment, service, or supply, unless otherwise required by law; or
- (iv) is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function; or
 - (v) is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.
- (b) Any Service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by Anthem. In determining whether a Service is Experimental or Investigational, Anthem will consider the information described in subsection (c) and assess the following:
- (i) whether the scientific evidence is conclusory concerning the effect of the Service on health outcomes;
 - (ii) whether the evidence demonstrates the Service improves the net health outcomes of the total population for whom the Service might be proposed by producing beneficial effects that outweigh any harmful effects;
 - (iii) whether 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
 - (iv) whether 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.
- (c) The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections (a) and (b) may include one or more items from the following list which is not all inclusive:
- (i) published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
 - (ii) evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
 - (iii) 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
 - (iv) documents of an IRB or other similar body performing substantially the same function; or
 - (v) consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
 - (vi) 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

- (vii) medical records; or
 - (viii) the opinions of consulting providers and other experts in the field.
- (d) Anthem identifies and weighs all information and determines all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

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.

Fertility Treatment

Procedures, products, medications and services intended to achieve pregnancy that results in a live birth with healthy outcomes and that are provided in a manner consistent with established medical practice and professional guidelines published by the American Society for Reproductive Medicine, its successor organization or a comparable organization.

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

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem BCBS for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem BCBS and the Group (also known as the Group 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 Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Habilitative Services

Healthcare services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Home Delivery Pharmacy

A service where you get Prescription Drugs (other than Specialty Drugs) through a mail order service.

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

Identification Card (ID Card)

The card we give you that shows your Member identification, Group numbers, and the plan you have.

Inborn Error of Metabolism

A genetically determined biochemical disorder in which a specific enzyme defect produces a metabolic block that may have pathogenic consequences at birth or later in life.

Infertility

The presence of a demonstrated condition recognized by a Provider as a cause of loss or impairment of fertility or a couple's inability to achieve pregnancy after 12 months of unprotected intercourse when the couple has the necessary gametes for conception, including the loss of a pregnancy occurring within that 12-month period, or after a period of less than 12 months due to a person's age or other factors. Pregnancy resulting in a loss does not cause the time period of trying to achieve a pregnancy to be restarted.

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 "How Your Plan Works" section for more information on how to find an In-Network Provider for this Plan.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Program

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary 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.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the “Eligibility and Enrollment – Adding Members” section for further details.

Maintenance Medications

Please see the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy section for details.

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90-day supply of Maintenance Medication

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the “Claims Payment” section.

Medically Necessary Health Care

Health care services or products provided to a Member for the purpose of preventing, diagnosing, or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of “best practices” in the medical profession; and
- Not primarily for the convenience of the member or physician or other health care practitioner.

When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. 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.

Medicare

The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called “you” and “your” in this Booklet.

Mental Health and Substance Abuse

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

Minimum Essential Coverage

The term means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's healthcare program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health or benefits risk pool.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members. Benefits are not available when you use Out-of-Network Providers, unless they are for Emergency or Urgent Care, or for services approved in advance by Anthem as an Authorized Service.

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. The Out-of-Pocket Limit may consist of Deductibles, Coinsurance, and/or Copayments. 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 than 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

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

Please see the section "Getting Approval for Benefits" for details.

Premium (also known as Subscription Charge)

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group'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 who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, obstetricians & gynecologists, 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.

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, 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. Examples of Providers include, but are not limited to: Clinical professional counselors, dentists, Doctors of Naturopathic Medicine, essential health care providers (rural health clinics) and essential community providers, registered nurse first assistants, social workers and psychiatric nurses.

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

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

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

Recovery

Please see the “Subrogation and Reimbursement” section for details.

Referral

Please see the “How Your Plan Works” section for details.

Rehabilitative Services

Healthcare services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Residential Treatment Center / Facility:

An Inpatient Facility that treats Mental Health and Substance Abuse 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.

Site of Service Provider

Site-of-Service (SOS) Providers are surgical, lab, radiology and diagnostic imaging centers that meet cost and other criteria established by Anthem. They are:

- A Provider that is not part of or owned by a Hospital and bills independently (i.e. not under a Hospital’s name or ID number.) Providers such as Radiology Providers, Reference Laboratories, and Ambulatory Surgery Centers meet these criteria and are considered “freestanding” Site-of-Service Providers.
- An outpatient Facility location owned by a Hospital that is contracted with Anthem and meets the criteria to be considered “Site-of-Service” (“SOS”).

These entities provide health care services such as surgery, laboratory tests, radiology and other services that are typically lower cost options for patients. Each participating Facility is subject to specific licensing, accreditation and credentialing requirements.

Skilled Nursing Facility

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. 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.

Surgical Assistant

A doctor (Doctor of Medicine or Osteopathy) or dentist (Doctor of Dental Medicine or Dental Surgery), or other qualified professionals as permitted by law and recognized by us who actively assists the operating surgeon in performing a covered surgical service.

Subscriber

An employee or member of the Group who is eligible for and has enrolled in the Plan.

Surprise Billing Claim

Please refer to the “Surprise Billing Protection Notices” at the front of this booklet for details.

Telehealth Services

The mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient’s physical and mental health.

Treatment of Autism Spectrum Disorders

The following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:

1. Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;
2. Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and
3. Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

Urgent Care / Walk-In 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 vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho sãe Dìch Vê Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (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 مجاناً. 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 bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

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

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>.



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