Plan Administered By:

Anthem Blue Cross and Blue Shield
(the trade name of Anthem Health Plans of Virginia, Inc.)

Anthem Blue Cross and Blue Shield
Post Office Box 27401
Richmond, VA 23261-7400
833-831-0085

Benefit Booklet

(Referred to as "Booklet" in the following pages)

KeyCare 500/20%/4500 Plan

Virginia Bankers Association

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

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

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ABCBS-VA-LG-PPO-ASO (1/23)

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 or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

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

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

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

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

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

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

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

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

Mental Health Parity and Addiction Equity Act

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

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the 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; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

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

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

Introduction

Welcome to Anthem!

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

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

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

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

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

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

ANTHEM BLUE CROSS AND BLUE SHIELD

President

How to Get Language Assistance

The Claims Administrator employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Identity Protection Services

Identity protection services are available with our Anthem health plans. To learn more about these services, please visit https://anthemcares.allclearid.com/.

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Schedule of Benefits

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

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

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section. This amount can be substantial. Please read the "Claims Payment" section for more details.
Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

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

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

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

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

Benefit Period	Calendar Year

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

Deductible	**In-Network**	**Out-of-Network**
Per Member	$500	$1,000
Per Family – All other Members combined	$1,000	$2,000

If you, the Subscriber, are the only person covered by this Plan, only the "per Member" amounts apply to you.

If you also cover Dependents (other family members) under this Plan, amounts will accumulate for each family member until the "per Family" amount is met, but no individual family member will contribute more than the "per Member" amount shown.

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

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

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

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

Reminder: 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. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section.
Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.

Out-of-Pocket Limit	**In-Network**	**Out-of-Network**
Per Member	$4,500	$6,000
Per Family – All other Members combined	$9,000	$12,000

If you, the Subscriber, are the only person covered by this Plan, only the "per Member" amounts apply to you.

If you also cover Dependents (other family members) under this Plan, amounts will accumulate for each family member until the "per Family" amount is met, but no individual family member will contribute more than the "per Member" amount shown.

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.

Out-of-Pocket Limit	**In-Network**	**Out-of-Network**
The Out-of-Pocket Limit does not include amounts you pay for following benefits: • Out-of-Network Human Organ and Tissue Transplant services. 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 except for the services listed above. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice about Your Cost Shares

In certain cases, if 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. If you have paid the Provider the amounts that are your responsibility, and such amounts have been paid twice, we will seek repayment from the Provider.

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

Benefits	**In-Network**	**Out-of-Network**
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 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.	20% Coinsurance after Deductible	
Ambulance Services (Ground, Air and Water) Non-Emergency Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. **Important Note:** All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.		
Autism Services	Benefits are based on the setting in which Covered Services are received.	
Behavioral Health Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Blood and Administration of Blood Products	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.	
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.	
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care."	Benefits for other diabetic equipment and supplies, including test strips, depend on whether the supplies are purchased from a medical supplier or a retail or home delivery pharmacy.	

Benefits	In-Network	Out-of-Network
	Benefits for diabetic education are based on the setting in which Covered Services are received.	
Diagnostic Services		
• Preferred Reference Labs	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
• All Other Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME), Medical Devices, and Supplies		
• Durable Medical Equipment	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Orthotics	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prosthetics	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Medical and Surgical Supplies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
The cost-shares listed above apply when your Provider submits separate bills for the equipment or supplies.		
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period In- and Out-of-Network combined	
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	20% Coinsurance after Deductible	
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon)	20% Coinsurance after Deductible	
• Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	20% Coinsurance after Deductible	

Benefits	In-Network	Out-of-Network
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance after Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	
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 able to travel using non-medical or non-emergency medical transport. Please refer to "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section for more details.		
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Therapy Services" for details on Benefit Maximums.	
Home Health Care		
• Home Health Care Visits from a Home Health Care Agency	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Home Dialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Home Infusion Therapy / Chemotherapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Specialty Prescription Drugs	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Home Health Care Services / Supplies	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Private Duty Nursing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Home Health Care Benefit Maximum	100 visits per Benefit Period In- and Out-of-Network combined The limit does not apply to Home Infusion Therapy or Home Dialysis.	
Private Duty Nursing Visits	16 hours per Calendar Year In- and Out-of-Network combined	
Home Infusion Therapy	See "Home Health Care."	

Benefits	In-Network	Out-of-Network
Hospice Care		
• Home Hospice Care	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
• Bereavement	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
• Inpatient Hospice	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
• Outpatient Hospice	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
• Respite Care	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Skilled Nursing Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Rehabilitation	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	150 days per Benefit Period In- and Out-of-Network combined	
• Mental Health / Substance Use Disorder Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Residential Treatment Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Ancillary Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Maternity	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Lymphedema	Benefits are based on the setting in which Covered Services are received.	
Maternity and Reproductive Health Services		
• Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) If you change Doctors during your pregnancy, or if a pregnancy ends prior to delivery or completion of care, the prenatal and postnatal fees will be filled separately.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
- Primary Care Physician / Provider (PCP)	$25 Copayment per visit	40% Coinsurance after Deductible
- Specialty Care Physician / Provider (SCP)	$50 Copayment per visit	40% Coinsurance after Deductible
• Inpatient Services (Delivery)	See "Inpatient Services."	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Use Disorder Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	

Benefits	In-Network	Out-of-Network
Occupational Therapy	See “Therapy Services.”	
Office and Home* Visits *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section. If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the “Outpatient Facility Services” section later in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
• Primary Care Physician / Provider (PCP) (Including In-Person and/or Virtual Visits)	In Person Visits: $25 Copayment per visit Virtual Visits: $25 Copayment per visit	40% Coinsurance after Deductible
• Mental Health and Substance Use Disorder Provider (Including In-Person and/or Virtual Visits)	In-Person Visits: $25 Copayment per visit Virtual Visits: $25 Copayment per visit	40% Coinsurance after Deductible
• Specialty Care Physician / Provider (SCP) (Including In-Person and/or Virtual Visits)	In-Person Visits: $50 Copayment per visit Virtual Visits: $50 Copayment per visit	40% Coinsurance after Deductible
• Retail Health Clinic Visit	$25 Copayment per visit	40% Coinsurance after Deductible
• Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders)	$25 Copayment per visit	40% Coinsurance after Deductible
• Nutritional Counseling for Eating Disorders	$25 Copayment per visit	40% Coinsurance after Deductible
• Allergy Testing		

Benefits	In-Network	Out-of-Network
- Primary Care Physician / Provider (PCP)	$25 Copayment per visit	40% Coinsurance after Deductible
- Specialty Care Physician / Provider (SCP)	$50 Copayment per visit	40% Coinsurance after Deductible
• Shots / Injections (other than allergy serum**)**	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Office Surgery (including anesthesia)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Physical Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Speech Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Occupational Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Dialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Cardiac Rehabilitation	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Pulmonary Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Orthotics	See "Durable Medical Equipment (DME), Medical Devices, and Supplies."	
Outpatient Facility Services		
• Facility Surgery Charge	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Facility Surgery Lab	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Facility Surgery X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Ancillary Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Doctor Surgery Charges	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests: EKG, EEG, etc.	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Therapy:		
– Chiropractic / Osteopathic / Manipulative Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Physical Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Speech Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Occupational Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Dialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Cardiac Rehabilitation	20% Coinsurance after Deductible	40% Coinsurance after Deductible
– Pulmonary Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical Therapy	See “Therapy Services.”	
Preventive Care	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
Preventive Care for Chronic Conditions (per IRS guidelines)		
• Medical items, equipment and screenings	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
Please see the “What’s Covered” section for additional detail on IRS guidelines.		

Benefits	In-Network	Out-of-Network
Prosthetics	See “Prosthetics” under “Durable Medical Equipment (DME), Medical Devices, and Supplies.”	
Pulmonary Therapy	See “Therapy Services.”	
Radiation Therapy	See “Therapy Services.”	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received. See “Inpatient Services” and “Therapy Services” for details on Benefit Maximums.	
Respiratory Therapy	See “Therapy Services.”	
Skilled Nursing Facility	See “Inpatient Services.”	
Speech Therapy	See “Therapy Services.”	
Surgery	Benefits are based on the setting in which Covered Services are received.	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
• Physical & Occupational Therapy	30 visits per Benefit Period	
• Speech Therapy	30 visits per Benefit Period	
• Manipulation Therapy	30 visits per Benefit Period	

Benefits	In-Network	Out-of-Network
• Cardiac Rehabilitation	36 visits per Benefit Period	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit. **Note:** When you get physical, occupational, speech therapy , or cardiac rehabilitation in the home, the Home Health Care Visit limit will apply instead of the Therapy Services limits listed above.		
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	
Urgent Care Services (Office and Home* Visits) *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
• Urgent Care Visit Charge	$50 Copayment per visit	40% Coinsurance after Deductible
• Allergy Testing	$50 Copayment per visit	40% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Office Surgery (including anesthesia)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
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 (Telemedicine/Telehealth Visits)		

Benefits	In-Network	Out-of-Network
• Medical Chats and Virtual Visits including Primary Care through our mobile app from our Preferred Online Provider	$0 Copayment per visit	Not Covered
• Virtual Visits from our Online Provider (Medical Services)	$0 Copayment per visit	Not Covered
• Virtual Visits from our Online Provider (Mental Health and Substance Abuse Services)	$0 Copayment per visit	Not Covered
• Virtual Visits from our Online Provider (Specialty Care Services)	$50 Copayment per visit	Not Covered
If Preventive Care is provided during a Virtual Visit, it will be covered under the "Preventive Care" benefit, as required by law. Please refer to that section for details.		
Vision Services (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.	

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

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

Centers of Excellence (COE) Transplant Providers

Blue Distinction Center Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery.

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

In-Network Transplant Provider: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant.

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

The requirements described below do not apply to the following:

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

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

	In-Network Transplant Provider	**Out-of-Network Transplant Provider**
Transplant Benefit Period	Starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts the day of a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Inpatient Facility Services • **Precertification required**	During the Transplant Benefit Period: 20% Coinsurance after Deductible. Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services,	40% Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit.

	Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will **not** have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you **will** have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Inpatient Professional and Ancillary (non-Hospital) Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Outpatient Facility Services	20% Coinsurance after Deductible.	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Outpatient Facility Professional and Ancillary (non-Hospital) Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	20% Coinsurance after Deductible.	40% Coinsurance after Deductible.

		These charges will NOT apply to your Out-of-Pocket Limit.
• **Transportation and Lodging Limit**	Covered, as approved by us, up to $10,000 per transplant In- and Out-of-Network combined	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	20% Coinsurance after Deductible.	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Donor Search Limit**	Covered, as approved by us, up to $30,000 per transplant In-and Out-of-Network combined	
Live Donor Health Services		
• **Inpatient Facility Services**	20% Coinsurance after Deductible.	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Outpatient Facility Services**	20% Coinsurance after Deductible.	40% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Donor Health Service Limit**	Medically Necessary charges for getting an organ from a live do are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

How Your Plan Works

Introduction

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

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

In-Network Services

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

If you receive Covered Services from an Out-of-Network Provider after we failed to provide you with accurate information in our Provider Directory, or after we failed to respond to your telephone or web-based inquiry within the time required by federal law, 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 complete authority to decide the Medical Necessity of the service. If you disagree with our determination, you have the right to file an appeal as described in the “Your Right to Appeal” section.

In-Network Provider Services

For services from In-Network Providers:

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

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

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

Note: Some provider practices participate in our networks as both Primary Care Providers and Urgent Care Centers. If the practice is not your Primary Care Provider, you may be responsible for the Urgent Care office visit cost share.

After Hours Care

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

Out-of-Network Services

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

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments (Please see the "Balance Billing by Out-of-Network Providers" section that follows for exceptions and more details.);

2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);

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

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

5. You may have to file claims; and

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

Balance Billing by Out-of-Network Providers

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

Surprise Billing Claims
Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:
- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

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

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

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

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to be travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to

receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

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

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your claims will be paid at the Out-of-Network benefit level if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This requirement does not apply to Ancillary Services. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this notice and consent process to you if Anthem does not have an In-Network Provider in your area who can perform the services you require.

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.

How Cost-Shares Are Calculated

Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. 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 will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider, Covered Services from an Out-of-Network Provider at an In-Network Facility, or Out-of-Network Air Ambulance Services and believe those services are covered by the No 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 "Your Right to Appeal" section of this Benefit Book.

Provider Directories

Anthem is required to confirm the list of In-Network Providers in its Provider Directory every 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. In addition to your In-Network cost-shares, the Out-of-Network Provider can also charge you for the difference between the Maximum Allowed Amount and their billed charges.

Transparency Requirements

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

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

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

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

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. To locate In-Network Providers, select "Find a Doctor", choose the type of provider you are searching for, your location, and under "What insurance plan would you like to use", select KeyCare.
- Search for a Provider in our mobile app.
- Contact Member Services to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

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

Continuity of Care

If your In-Network Provider leaves our networkfor any reason other than termination for cause, and you are in an active course of treatment, you may be able to continue seeing that Provider for a limited period of time and still get In-Network benefits. We reimburse terminated Providers in accordance with the participation agreement that existed immediately prior to the Provider's termination of participation. "Active course of treatment" for any course of medically necessary continuing care includes, but is not limited to:

1) An active course of treatment for an illness,
2) An ongoing course of treatment for a life-threatening condition,
3) An ongoing course of treatment for a serious acute condition (examples include chemotherapy, radiation therapy and post-operative visits),

4) An ongoing course of treatment for pregnancy and through the postpartum period,
5) An ongoing course of treatment for a Member who is terminally ill as defined by the Social Security Act, or
6) An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen your condition or interfere with anticipated outcomes.

An “active course of treatment” includes treatments for Mental Health and Substance Use Disorders.

For Members who are terminally ill, coverage is extended for the remainder of the person’s life for the direct care of the terminal illness. For Members who are in the second or third trimester of pregnancy, coverage is extended through the postpartum care for that delivery. In all other circumstances, you may be able to continue seeing that Provider for 90 days. If you wish to continue seeing the same Provider, you or your Doctor should contact Member Services for details.

In the absence of proper authorization for coverage at the In-Network level, you may choose to receive services on an out-of-plan basis.

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.

Crediting Prior Plan Coverage

If you were covered by the Employer’s prior carrier / plan immediately before the Employer signs up with us, with no break in coverage, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket amounts 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 Employer’s coverage with us began, or to people who join the Employer later.

If your Employer 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 Employer 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 Employer 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 Employer 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 who joins the Employer after the Employer's initial enrollment with us.

The BlueCard Program

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

Identification Card

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

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/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.

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 coverage and clinical guidelines. Anthem, on behalf of the Employer, may decide that a service that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate.

If you have any questions about the information in this section, you may call the Member Services phone number on the back of your Identification Card.

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

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

Types of Reviews

- **Pre-service Review –** A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.
    - **Precertification –** A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet. For admissions following Emergency Care, you, your authorized representative or Doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Childbirth admissions continuing beyond 48/96 hours from delivery require precertification. Continued Stay admissions occur when there is a problem and/or the mother and baby are not sent home at the same time.

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

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

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not

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

How Decisions are Made

We use our clinical coverage 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." Coverage and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right, on behalf of the Employer, to review and update these clinical coverage guidelines from time to time.

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

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

Decision and Notice Requirements

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

Type of Review	**Timeframe Requirement for Decision and Notification**
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Concurrent / Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Concurrent / Continued Stay Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Concurrent / Continued Stay Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make 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 the 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

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

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.

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

Health Plan Individual Case Management

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

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

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

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

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

What's Covered

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

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

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

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, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for your condition. In certain cases 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.

Balance billing is prohibited for out-of-network emergency air ambulance services.

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

Hospital to Hospital Transport

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

Autism Services

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

- diagnosis of autism spectrum disorder;
- treatment of autism spectrum disorder;

- pharmacy care;
- psychiatric care;
- psychological care; and
- therapeutic care.

Treatment for ASD includes applied behavior analysis when provided or supervised by a board certified behavior analyst, licensed by the Board of Medicine, and billed by such behavior analyst, and the prescribing practitioner is independent of the provider of the applied behavior analysis.

Treatment for ASD also includes physical, occupational and speech therapy services. When associated with a diagnosis of ASD, these services will not apply to the benefit maximums for these services set forth in the “Therapy Services” section of the Schedule of Benefits.

Behavioral Health Services

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

Blood and Administration of Blood Products

Your Plan includes coverage for blood and the administration of blood products for the treatment of Hemophilia and congenital bleeding disorders.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractor Services

Please see “Therapy Services” later in this section.

Clinical Trials

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

Benefits are limited to the following trials:

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

    a. The National Institutes of Health.

    b. The Centers for Disease Control and Prevention.

    c. The Agency for Health Care Research and Quality.

    d. The Centers for Medicare & Medicaid Services.

e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

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

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

   i. The Department of Veterans Affairs.

   ii. The Department of Defense.

   iii. The Department of Energy.

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

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

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

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

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

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

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

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, 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 appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered.

Hospitalization for Anesthesia and Dental Procedures

Your plan includes coverage of general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or Outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the covered person's treating physician that such services are required to effectively and safely provide dental care.

Diabetes Equipment, Education, and Supplies

Your Plan covers medical supplies, equipment, and education for diabetes care for all diabetics. This includes coverage for the following:

- insulin pumps;
- diabetic supplies needed for monitoring and dosing, including stand alone or continuous home glucose monitors, lancets, blood glucose test strips, hypodermic needles and syringes, and related pump supplies; and
- outpatient self-management training and education performed in-person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional.

Benefits for diabetic supplies are covered when purchased from a medical supplier, subject to the Medical Supply cost share shown on the Schedule of Benefits..

Diabetic education may be received from pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service. Your Plan also covers treatment of corns, calluses and care of toenails for patients with diabetes or vascular disease.

Screenings for gestational diabetes are covered under Preventive Care.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist, as well as benefits for interpretation of diagnostic tests such as imaging, pathology reports, and cardiology. 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 Sleep Testing

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Radiology (including mammograms), ultrasound or nuclear medicine
- 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
- Single Photon Emission Computed Tomography (SPECT) scans

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 costs to maintain the equipment/device, such as repair, and when necessary, 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. Benefits are also available for nebulizers, traction equipment, and walkers.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, adjustment, 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 and components when they are Medically Necessary for activities of daily living. A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot or eye. Coverage is also included for the repair, fitting, adjustments and replacement of a prosthetic device. In addition, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of the prosthetic device.

Covered Services may include, but are not limited to:

1) Artificial limbs and components (the materials and equipment needed to ensure the comfort and functioning of the prosthetic device).
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) and surgical bras after a mastectomy, 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 needed after cancer treatment, limited to the maximum shown in the Schedule of Benefits.
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.

Medical Formulas

Your Plan covers special medical formulas as medicine and the medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products. Special medical formulas are a critical source of nutrition for covered persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

Devices and Supplies for Sleep Treatment

Your Plan includes coverage for devices and supplies, such as APAP, CPAP, BPAP and oral devices for sleep treatment. These services are subject to Medical Necessity reviews by us.

Early Intervention Services

Your Plan covers early intervention services for Dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;
- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by the Department are those services listed above which are determined to be Medically Necessary by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not Medically Necessary. The benefit maximums for physical, occupational, and speech therapy will not apply if you get that care as part of the Early Intervention benefit.

Emergency Care Services

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

Emergency Services

Benefits are available in a Hospital Emergency Room or independent freestanding Emergency Facility for services and supplies to treat the onset of symptoms for an Emergency, which is defined below. Please see the "Emergency Room Services" section in the "Schedule of Benefits" for an outline of the benefits included in your plan. **Services that do not meet the definition of Emergency will not be covered.**

Emergency (Emergency Medical Condition)

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

Emergency Care

"Emergency Care" means a medical or behavioral health screening exam done in the Emergency Department of a Hospital or independent freestanding Emergency Facility, and includes services routinely available in the Emergency Department to evaluate an Emergency Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient. Stabilize means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

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 as outlined in “Balance Billing by Out-of-Network Providers” in the “How Your Plan Works” section. You will still be responsible for any applicable Coinsurance, Copayment or Deductible. 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.

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

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

Treatment you get after your condition has stabilized and you are able to travel using non-medical or non-emergency medical transport is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover them as an Authorized Service.

Habilitative Services

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

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

Home Health Care Services

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

Covered Services include but are not limited to:

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

- Medically Necessary remote patient monitoring, see the “Virtual Visits” section for more details
- Private duty nursing

When available in your area, benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the “Mental Health and Substance Use Disorder Services” section below.

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

Home Infusion Therapy

Please see “Therapy Services” later in this section.

Hospice Care

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

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care to include palliative and supportive physical, psychological, psychosocial and other health services.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care. Coverage includes short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the covered person in order to provide the covered person’s primary caregiver a temporary break from caregiving responsibilities.
- 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 pain management and the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member’s death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated caregiver and individuals with significant personal ties for one year after the Member’s death.

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

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

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

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

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

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

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

Covered Transplant Procedure

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

Centers of Excellence (COE) Transplant Providers

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

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

In-Network Transplant Provider

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

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

Out-of-Network Transplant Provider

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

Transplant Benefit Period

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

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

Prior Approval and Precertification

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

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

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

Transportation and Lodging

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

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

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

- Child care,
- Mileage within the medical transplant Facility city,

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

Infertility Services

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

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting*.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for 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 (including hypodermic needles and syringes), casts, and splints.
- Blood and blood products.
- 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.

Lymphedema

Your Plan includes benefits for expenses incurred in connection with the treatment of lymphedema, including benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education.

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 for enrolled female members **,** Spouses and Dependents include:

- Pregnancy testing;
- Professional and Facility services for childbirth including use of the delivery room and care for normal deliveries, in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Anesthesia services to provide partial or complete loss of sensation before delivery;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal and postpartum services for the mother (including maternity-related checkups);
- Home care visit(s) for postpartum care;
- Postnatal services for the baby, including behavioral assessment and measurement; hemoglobinopathies screening; gonorrhea prophylactic medication; hypothyroidism screening, PKU screening and Rh incompatibility testing; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of generic and/or chromosomal anomalies.

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.

In the event you have a newborn experiencing a life-threatening emergency condition, you are not required to obtain prior authorization for the inter-hospital transfer of your newborn or the hospitalized mother of such newborn infant to accompany the infant.

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

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

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

Sterilization Services

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

Abortion Services

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

Infertility Services

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

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

Mental Health and Substance Use Disorder Services

Covered Services to diagnose and treat mental health or substance use disorder conditions, including psychiatric conditions and eating disorders, include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include professional provider services at a facility, individual psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, electroconvulsive therapy, detoxification, and rehabilitation.

- **Residential Treatment** which is specialized 24-hour 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, including availability of 24-hour nursing care.
    - Structured program of treatment, rehabilitation and therapy.

- **Partial Hospitalization/Day Treatment Programs and Intensive Outpatient Programs** are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital. Specific program requirements and details are included in the Definitions section under Partial Hospitalization Program and Intensive Outpatient Program.

- **Outpatient Services** including office visits, professional provider services at a facility, therapy and treatment, and (when available in your area) Intensive In-Home Behavioral Health Services. Covered services include individual psychotherapy, group psychotherapy, psychological testing and medication management visits (visits to your physician to make sure that the medication you are taking for a Mental Health or Substance Use Disorder is working and the dosage is right for you).

- **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.),
- Clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C), or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office and Home Visits

Covered Services include:

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

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

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

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

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

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

Prescription Drugs Administered in the Office

Orthotics

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgery Center,
- Mental Health / Substance Use Disorder 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 (including hypodermic needles and syringes), casts, and splints,
- Blood and blood products,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

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

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

Covered Services fall under the following broad groups:

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

a. Breast cancer,
b. Cervical cancer,
c. Colorectal cancer,
d. High blood pressure,
e. Type 2 Diabetes Mellitus,
f. Cholesterol,
g. Child and adult obesity.

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

3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration (including infant hearing screening);

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

   a. Women's contraceptives, sterilization treatments, and counseling. Coverage includes contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants.
   b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
   c. Gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.
   d. Testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of Pap smear results.
   e. Annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women.
   f. Screening and counseling for interpersonal and domestic violence.
   g. Well woman visits, including BRCA screenings.

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 counseling.

6. Counseling services related to nutrition.

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

Preventive Care for Chronic Conditions (per IRS guidelines)

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

Please see “Therapy Services” later in this section.

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. The following items and services will be provided to you as an inpatient in a skilled nursing bed of a Skilled Nursing Facility:

- room and board in semi-private accommodations;
- rehabilitative services; and
- drugs, biologicals, and supplies furnished for use in the Skilled Nursing Facility and other Medically Necessary services and supplies.

Your Plan will cover the private room charge if you need a private room because you have a contagious condition or are at greater risk of contracting an infectious disease because of your medical condition. Otherwise, your inpatient benefits would cover the Skilled Nursing Facility’s charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your Copayment or Coinsurance (if any).

Smoking Cessation

Please see “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;
- Surgeries and procedures to correct congenital abnormalities that cause Functional Impairment and congenital abnormalities in newborn children;
- 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.

Important Note About Hysterectomy Admissions: Hospital admissions for a covered laparoscopy-assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveolectomy when related to tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone 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.
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

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

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

Mastectomy Notice

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

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

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

Important Note About Mastectomy Admissions: Hospital admissions for covered radical or modified radical mastectomy for the treatment of breast cancer shall be approved for a period of no less than 48 hours. Hospital admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours.

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. Coverage for these Covered Services is described more completely under Rehabilitation Services and Habilitative Services earlier in this section. 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. Coverage includes benefits for physical therapy to treat lymphedema. It does not include massage therapy services.
- **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 teach, 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 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.

- **Acupuncture** – Treatment of neuromuscoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

Early Intervention Services

See “Early Intervention Services” earlier in this section.

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) with the goal of restoring, maintaining, teaching, or improving the physiological, psychological, social and vocational capabilities of patients with heart disease. Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility or doctor’s office. 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. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive rehabilitation therapy –** Only when Medically Necessary following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, cobalt, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), rental or purchase costs of materials and supplies needed, administration, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

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

Urgent Care Services

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

Benefits for urgent care may include:

- X-ray services;
- 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 internet-based video, chat, or voice. This includes visits with Providers who also provide services in person, as well as online-only Providers, and Primary Care 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 messagingthrough our mobile app; interactive store and forward (asynchronous) technology; or remote patient monitoring technology. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. In-person contact between a 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.

  "Remote patient monitoring" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

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, audio-only telephone, 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 and Home Visits."

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

Vision Services (All Members / All Ages)

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

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

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. Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by this Plan.

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, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of a Prescription Drug List (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 drugs are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Non-FDA approved, 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 the decision to both you and your Provider.

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

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

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

Designated Pharmacy Provider

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

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

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

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level. However, You will have In-Network coverage for Prescription Drugs that are provided by an In-Network Provider that is not a Designated Pharmacy Provider if such In-Network Provider or its intermediary has notified us or our PBM of its agreement to execute a Designated Pharmacy Provider Agreement applicable to Designated Pharmacy Providers.

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 Substitution

Therapeutic substitution is an optional program that tells you and your Doctors 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 substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

What's Not Covered

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

1) **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 speech aid devices and tracheo-esophageal voice devices approved by us.

4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:

   a) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
   b) Holistic medicine,
   c) Homeopathic medicine,
   d) Hypnosis,
   e) Aroma therapy,
   f) Massage and massage therapy,
   g) Reiki therapy,
   h) Herbal, vitamin or dietary products or therapies,
   i) Naturopathy,
   j) Thermography,
   k) Orthomolecular therapy,
   l) Contact reflex analysis,
   m) Bioenergial synchronization technique (BEST),
   n) Iridology-study of the iris,
   o) Auditory integration therapy (AIT),
   p) Colonic irrigation,
   q) Magnetic innervation therapy,
   r) Electromagnetic therapy,
   s) Neurofeedback / Biofeedback.

5) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) unless Medically Necessary.

6) **Autopsies** Autopsies and post-mortem testing unless requested by us as stated in "Physical Examinations and Autopsy" in the "General Provisions" section.

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.

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

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. The exception to this exclusion is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section.

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, 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 Drugs** Compound Drugs unless all of the ingredients are FDA approved, 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 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:

    a) Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process.

    b) Surgery or procedures to correct congenital abnormalities that cause Functional Impairment.

    c) Surgery or procedures on newborn children to correct congenital abnormalities.

16) **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.

17) **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.

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 Treatment** Dental treatment, except as listed below.

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

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

    Dental treatment for injuries that are a result of biting or chewing is also excluded.

    This Exclusion does not apply to services that we must cover by law.

22) **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.

23) **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.

24) **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.

25) **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.

26) **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.

27) **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.

28) **Emergency Room Services for non-Emergency Care** Services provided in an emergency room that do not meet the definition of Emergency. This includes, but is not limited to, suture removal in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.

29) **Experimental or Investigational Services** Services or supplies that are found to be Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

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

    Please see the "Clinical Trials" section of "What's Covered" for details about coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. Please also read the "Experimental or Investigational" definition in the "Definitions" section at the end of this Booklet for the criteria used in deciding whether a service is Experimental or 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 or accidental injury.

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) **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.

    This Exclusion does not apply to the treatment of corns, calluses, and care of toenails when the services are medically necessary.

35) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

36) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

37) **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.

38) **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.

39) **Gene Therapy** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

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. The exception to this Exclusion is homemaker services as described under "Hospice Care" in the "What's Covered" section.

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

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

46) **Infertility Treatment** Testing or treatment related to infertility.

47) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

48) **Maintenance Therapy** 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.

49) **Medical Chats Not Provided through Our Mobile App** Texting or chat services provided through a service other than our mobile app.

50) **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.

51) **Medicare** For which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled “Medicare” in “General Provisions.” If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to www.medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

52) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.

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 must be covered by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

57) **Off label use** Off label use unless we approve it.

58) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

59) **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) Hypoallergenic pillows, mattresses, or waterbeds,

f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

60) **Prescription Drugs** Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy.

61) **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Health Care Services" benefit.

62) **Prosthetics** Prosthetics for sports or cosmetic purposes.

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. Licensed professional counseling, as described in the "What's Covered" section of this Booklet, and provided as part of these programs, is considered a Covered Service.

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

66) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

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

68) **Sterilization** Services to reverse elective sterilization.

69) **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).

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

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

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

73) **Vision Services** Vision services not described as Covered Services in this Booklet.

74) **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.

75) **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, LA Weight Loss) and fasting programs.

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

77) **Wilderness or other outdoor camps and/or programs.** Licensed professional counseling, as described in the “What’s Covered” section of this Booklet, and provided as part of these programs, is considered a Covered Service.

Claims Payment

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

Maximum Allowed Amount

General

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

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

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

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. 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. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section. Please refer to that section for more details.

When you receive Covered Services from a 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, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

“Per diem amount” means an all-inclusive fixed payment amount for each day of admission in an inpatient facility.

Provider Network Status

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

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

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

Except for claims subject to the balance billing provisions outlined in “Balance Billing by Out-of-Network Providers” in the “How Your Plan Works” section, we will calculate the Maximum Allowed Amount for Covered Services you receive from an Out-of-Network Provider using one of the following:

1. An amount based on our non-participating Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: the statewide average reimbursement amounts that Anthem previously has paid for similar claims in the Commonwealth of Virginia, reimbursement amounts accepted by like/similar Providers contracted with Anthem, reimbursement rates accepted by Providers under the last network contract in effect 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 and/or method of reimbursement used by CMS, Anthem will update such information, 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.

A per diem amount may be used in calculating the Maximum Allowed Amount for Inpatient facility services. When calculating these amounts, the charges for non-Covered Services are subtracted from the per diem amount.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount or if your claim is subject to the balance billing provisions outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section.

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's Service Area, or a special negotiated price.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com.

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

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

Member Cost Share

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

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

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits. The Maximum Allowed Amount for Inpatient facility services may be based on a per diem amount. When calculating these amounts, the charges for non-Covered Services are subtracted from the per diem amount.

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

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

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

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

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section. Please contact Member Services for Authorized Services information or to request authorization.
The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

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

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

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

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your In-Network Copayment of $25, your total out of pocket expense would be $325. The exception outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section may further affect your total liability. Please see that section for additional details.

Federal/State Taxes/Surcharges/Fees

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

Claims Review

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

Written notice of a claim is to be made within 20 days after the occurrence or commencement of any loss covered by the health plan. However, failure to give this notice shall not invalidate or reduce any claim if the notice is given as soon as reasonably possible. After you get Covered Services, we must receive written notice of your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, you may have some extra time to file a claim. If we did not get your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), you may still be able to get benefits. **However, except in the absence of legal capacity of the Covered Person, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied, unless an extension is required by federal law.**

All benefits payable for a claim will be payable within 60 days after receipt of the proof of loss.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for a claims form to us, or contact Member Services and ask for a claims form to be sent to you. Claim forms will be furnished to you if needed within 15 days after this written notice. If you do not receive the claims form, written notice of services rendered may be submitted to us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

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 the Plan to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Plan reserves the right to make payments directly to you as opposed to any Out-of-Network 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 Plan), or that person's custodial parent or designated representative. Any payments made by the Plan (whether to any Provider for Covered Service or You) will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, the Plan 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.

Once a claim has been processed, if your portion of the bill is anything other than zero or equal to a flat copayment amount, a paper copy of the Explanation of Benefits (EOB) statement will be mailed to you to explain your responsibility. In the event that your portion of the bill is zero or equal to a flat copayment amount, the paper copy will not be mailed, but will be available to you online at www.anthem.com. If you do not have access to the Internet, you may contact Member Services to arrange for a printed copy.

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

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

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

B. Negotiated (non–BlueCard Program) Arrangements

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

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

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

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

E. 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. The exception to this is outlined in "Balance Billing by Out-of-Network Providers in the "How Your Plan Works" section.

F. Blue Cross Blue Shield Global Core® Program

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

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.bcbsglobalcare.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 (COB)

Special coordination of benefits (COB) rules apply when you or members of your family have additional health care coverage through other group health plans, including:

- Any auto liability, no fault, personal injury protection, or medical payment insurance policy;
- group insurance plans, including other Blue Cross and Blue Shield plans or HMO plans;
- labor management trustee plans, union welfare plans, Employer welfare plans, Employer organization plans, or Employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

All benefits provided under this agreement are subject to this provision. However, benefits will not be increased by this COB provision. When you are covered by more than one group health plan, your benefits under this Plan will be coordinated with the benefits of those Other Plans so that the benefits and services you receive from all group coverages do not exceed 100% of the Maximum Allowed Amount.

Primary Coverage and Secondary Coverage

When a member is also enrolled in another group health plan, one coverage will pay benefits first (be primary) and the other will pay second (be secondary). The primary coverage will pay benefits first. The decision of which coverage will be primary or secondary is made using benefit determination rules.

When this health plan provides secondary coverage, we first calculate the amount that would have been payable had this health plan been primary. Then we coordinate benefits so that the combination of the primary plan's payment and this health plan’s payment does not exceed the amount this health plan would have paid had it been primary. When the primary coverage provides benefits in the form of services rather than payment, a reasonable cash value of the services will be assigned and then considered to be the benefit payment.

Calculation of the amount that would have been payable does not include 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.

Definition of “Other Contract”

Other Contract means any arrangement providing health care benefits or services through:

- group or blanket insurance coverage;
- group Blue Cross Blue Shield, health maintenance organization, and other prepayment coverage;
- coverage under labor management trusteed plans, union welfare plans, Employer organization plans, or Employee benefit organization plans; and
- coverage under any tax supported or government program to the extent permitted by law.

If there is more than one Other Contract, this provision will apply separately to each. If an Other Contract has a coordination of benefits provision that applies to only part of its services, the terms of this paragraph will be applied separately to that part and to any other part.

When benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the benefit.

Anthem will not determine the existence of any Other Contract, or the amount of benefits payable under any Other Contract except this agreement. The payment of benefits under this agreement shall be affected by the benefits payable under Other Contracts only when Anthem is given information about Other Contracts.

If the rules of this agreement and the Other Contract both provide that this agreement is primary, then this agreement is primary. When Anthem determines that this agreement is secondary under the rules described below, benefits will be coordinated so that our payment plus the Other Contract's payment will not exceed Anthem's Maximum Allowed Amount for covered services.

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

Order of Benefit Determination Rules

If coverage under a contract is taken out in the name of a covered person, then that contract will be primary for that covered person. However, if the person is also entitled to Medicare, and as a result of federal law Medicare is:

- secondary to the contract covering the person as a Dependent; and
- primary to the contract covering the person as other than a Dependent (e.g., a retired Employee);
- then the benefits of the contract covering the person as a Dependent are determined before those of the contract covering the person as other than a Dependent.

For children who are covered under both parents' contracts, the following will apply:

- The contract of the parent whose birthday occurs earlier in the calendar year will be primary.
- When parents are separated or divorced, the following special rules will apply:
    - If the parent with custody has not remarried, that parent's contract will be primary.
    - If the parent with custody has remarried, that parent's contract will be primary and the stepparent's contract will be secondary. The benefits of the contract of the parent without custody will be determined last.
    - The rules listed above may be changed by a court decree:
        - A court decree that orders one of the parents to be responsible for health care expenses will cause that parent's contract to be primary, but only if the entity providing the benefits in this case is notified of the court decree before applying benefits.
        - If the court decree does not state that one of the parents is responsible for health care expenses and both parents have joint custody, the contract of the parent whose birthday occurs earlier in the calendar year will be primary.

If the Other Contract includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father's contract will be primary for the children.

If there are situations not covered above, then the contract that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The contract that covers a working Employee (or his Dependent) will be primary. The contract of a laid-off Employee, a retired Employee, or a person on continuation of coverage options under federal or state law will be secondary.

If an Other Contract has different rules from those listed above other than the gender rule, that contract will be primary.

If payments should have been made under this agreement under the rules of this provision, but they have been made under any Other Contract, Anthem may pay an entity (provider, other carrier, etc.) that has paid any amounts it determines will meet the intent of this provision. These amounts shall be deemed to be benefits paid under this agreement. Upon this payment, Anthem will no longer be liable under this agreement.

The preceding paragraph does not apply to claims for outpatient prescription drugs provided by a pharmacy when Medicare Part D provides the covered person's primary prescription drug coverage. See the following section for more information.

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

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

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.

- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.

- Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.

- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

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

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

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

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

- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred, all information regarding the parties involved and any other information requested by the Plan.

- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

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

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

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

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

Member Rights and Responsibilities

As a Member you have rights and responsibilities when receiving health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That means giving you access to our network of Doctors and healthcare professionals, who help you make the best decisions for your health.

You have the right to:

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

You have the responsibility to:

- Read all information about your benefits under the Plan and ask for help if you have questions.
- Follow all Plan rules and policies.
- Choose an In-Network Primary Care Physician, also called a PCP, if your Plan requires it.
- Treat all health care professionals and staff with respect.
- Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.
- Understand your health challenges as well as you can and work with your Doctors and other healthcare professionals to create an agreed upon treatment plan.
- Inform your Doctors and other health care professionals if you don't understand the type of care you're getting or what they want you to do as part of your care plan.
- Follow the treatment plan that you have agreed upon with your Doctors and other healthcare professionals.
- Share the information needed with us, your Doctors, and other healthcare professionals to help you get the best possible care. This may include information about other health insurance benefits you have in addition to your coverage with us.
- Inform Member Services if you have any changes to your name, address or family members covered under your Plan.

If you would like more information, have comments, or would like to contact us, please go to www.anthem.com and select Customer Support > Contact Us or call the Member Services number on your ID card.

We are here to provide high quality benefits and services to our Members. Benefits and coverage for services given under the Plan are governed by the Booklet and not by this Member Rights and Responsibilities statement.

Your Right to Appeal

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about the Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card. The Plan will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file an appeal, which is defined as follows:

Complaints typically involve issues such as dissatisfaction about the Plan's services, quality of care, the choice of and accessibility to the Plan's providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by the Plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will receive a response within 30 calendar days of the Plan's receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, you will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to you within an additional 30 calendar days.

Written complaints may be filed to the following address:

Anthem Blue Cross and Blue Shield
Attention: Appeals
P.O. Box 27401
Richmond, VA 23279

Appeal Process

Anthem, on behalf of the Employer, is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions you find unacceptable, whether the decision is a claim denial or a rescission of coverage. A rescission is a retroactive termination of coverage, other than when it is attributable to a failure to timely pay required Fees or contributions towards the cost of coverage.

There are two types of appeals. Internal appeals are requests to reconsider rescissions or coverage decisions of pre-service or post-service claims. Expedited appeals are made available when the application of the time period for making pre-service or post-service appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment.

How to Appeal a Coverage Decision

To appeal a coverage decision (including a rescission), please send a written explanation of why you feel the coverage decision was incorrect. You or your authorized representative acting on your behalf may submit the written explanation. Alternatively, this information may be provided to a Member Services representative over the phone. This is your opportunity to provide any comments, documents, or information that you feel the Plan should consider when reviewing your appeal.

Please include with the explanation:

- the patient's name, address and telephone number;
- your identification and group number (as shown on your identification card); and
- in the case of a claim, the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

You may contact Member Services with your appeal or any questions concerning your health insurance. To contact Member Services please call the number on the back of your Identification Card. When submitting your appeal in writing, it should be sent to the following address:

For Medical and Prescription Drug or Pharmacy Issues:
Anthem Blue Cross and Blue Shield
Attention: Appeals
P.O. Box 27401
Richmond, VA 23279

You must file your appeal within 180 days of the date you were notified of the adverse benefit determination.

Limitation of Actions

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.

How Anthem Will Handle Your Appeal

In reviewing your appeal, the Plan will take into account all the information you submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a clinical peer reviewer. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

The Plan will promptly acknowledge receipt of your appeal, and will resolve and respond to it as follows:

- For pre-service claims, we will respond in writing within 30 days after receipt of the request to appeal;
- For post-service claims and rescissions, we will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, we will respond to you and your provider as soon as possible taking into account your medical condition, but not later than 72 hours from receipt of the request.

The Plan will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination based on new or additional rationale, we will provide you, free of charge, with the rationale. When the Plan's review of your appeal has been completed, you will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. You will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;

- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

Notice of Adverse Benefit Determination

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

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

For claims involving urgent/concurrent care:

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

External Review

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

A request for external review must be in writing unless the Plan determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted as part of the internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

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

- the identity of the claimant;
- The date (s) of the medical service;

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

All other requests for external review should be submitted in writing unless the Plan determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Address:
Anthem Blue Cross and Blue Shield
Attention: Appeals
P.O. Box 27401
Richmond, VA 23279

Your decision to seek external review will not affect your rights to any other benefits under this Plan. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to File an Appeal Before Filing a Lawsuit

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

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

Eligibility and Enrollment – Adding Members

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

Who is Eligible for Coverage

The Subscriber

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

- Be an Employee, member of the Employer, and
- Be entitled to participate in the benefit Plan arranged by the Employer;
- Have satisfied any probationary or waiting period established by the Employer and
- and perform the duties of your principal occupation for the Employer.

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 Employer, and be one of the following:

- The Subscriber's legally married Spouse.

- The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex certifying that he or she is the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

  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 Employer 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:

- The age limit does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of intellectual impairment, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the subscriber provides proof of impairment and

dependence at the time of enrollment. For the child enrolled prior to reaching the age limit, coverage may continue beyond the age limit if the subscriber provides proof of impairment and dependence within 31 days after he/she reaches the age limit. You may be asked to provide physician's certification of the Dependent's condition. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

You may be required to give proof of continued eligibility for any enrolled child. Your failure to give this information could result in termination of a child's coverage.

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

Types of Coverage

Your Employer 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 child(ren);
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Employer will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Employer, 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 Employer will notify you when Open Enrollment is available.

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 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 Fees 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 Employer's Prior Plan

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

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth when properly enrolled for coverage. Following the birth of a child, you must submit an application / change form to the Employer within 31 days to add the newborn to your Plan.

Even if no additional Fees are required, you must still submit an application / change form to the Employer 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**.**

When adoptive or parental placement occurs within 31 days of birth, such child shall be considered a newborn child of the insured, covered automatically for the first 31 days, as outlined in the Newborn Children section.

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 Employer of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Employer and complete the appropriate forms:

- Changes in address;
- Marriage or divorce;
- Death of an enrolled family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see “Termination and Continuation of Coverage”);
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

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

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age. Providers operating within the scope of practice, license or certification cannot be discriminated against.

Statements and Forms

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

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

Termination and Continuation of Coverage

Termination

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

- When the Administrative Services Agreement between the Employer and us terminates. It will be the Employer's responsibility to notify you of the termination of coverage.

- If you choose to terminate your coverage.

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

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

- at 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 Allowable Amount for such services, less any Copayments made or Fees paid for such services.

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

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

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

Removal of Members

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

Continuation of Coverage Under Federal Law (COBRA)

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

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

Qualifying Events for Continuation Coverage Under Federal Law (COBRA)

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

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

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

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

If Your Employer Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second Qualifying Event

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

Notification Requirements

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

You Must Give Notice of Some Qualifying Events

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

Electing COBRA Continuation Coverage

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

Disability Extension of 18-month Period of Continuation Coverage

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

longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

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

When COBRA Coverage Ends

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

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

Other Coverage Options Besides COBRA Continuation Coverage

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

If You Have Questions

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

Continuation of Coverage Due To Military Service

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

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

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

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

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

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

Maximum Period of Coverage During a Military Leave

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

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

Reinstatement of Coverage Following a Military Leave

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

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

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

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

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

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

Family and Medical Leave Act of 1993

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

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

General Provisions

Assignment

The Employer cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in this Booklet.

Care Coordination

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

Confidentiality and Release of Information

Applicable 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 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 federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Employer and us, Anthem Health Plans of Virginia, 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 Commonwealth of Virginia. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S.

Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Employer, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to the Employer for any of Anthem‘s obligations to the Employer created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Employer Waiver

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

Employer’s Sole Discretion

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

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of the Employer.

Government Programs

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

Medical Policy and Technology Assessment

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.

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 enrolled in Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to www.medicare.gov for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

Modifications

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

Not Liable for Provider Acts or Omissions

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

Payment Innovation Programs

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

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

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

Policies, Procedures, and Pilot Programs

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

Under the terms of the Administrative Service Agreement with your Employer, we have the authority, in our discretion, to institute from time to time, utilization management, disease management, care management, case management, clinical quality, wellness or behavioral health pilot initiatives in certain

designated geographic areas. These pilot initiatives are part of our ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan, unless otherwise agreed to by the Employer. We reserve the right to discontinue a pilot initiative at any time without advance notice to Employer.

Program Incentives

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

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

Relationship of Parties (Anthem and In-Network Providers)

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

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

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

Reservation of Discretionary Authority

We, as the Claims Administrator, shall have all the powers necessary or appropriate to enable us to carry out our duties in connection with the operation of the Plan and interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A

specific limitation or exclusion will override more general benefit language. We have complete discretion to interpret the Benefit Booklet. Our determination may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Right of Recovery and Adjustment

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

We, as the Claims Administrator, have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. The Claims Administrator reserves the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-of-Network claims where the Out-of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

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

Value-Added Programs

We may offer health or fitness related programs to the Plan’s Members, through which Members 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 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 the Plan paid for the Covered Services.

Voluntary Clinical Quality Programs

The Plan may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. The Plan will give you the choice and if you choose to participate in one of these programs, and obtain the

recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which the Plan encourages you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to 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 Employer 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 Employer 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 an Employer may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

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 the Plan if it has made or makes payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Definitions

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

Accidental Injury

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

Administrative Services Agreement

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

Ambulatory Surgery Center

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

Applied Behavior Analysis

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

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that 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. Please see "Claims Payment" for more details. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Plan Works" section.

Autism Spectrum Disorder

Means any pervasive developmental disorder or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

For Autism Spectrum Disorder, Medically Necessary means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

Benefit Period

The length of time the Plan will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Employer's effective or renewal date and lasts for 12 months. (See your Employer 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 the Plan will cover for a Covered Service during a Benefit Period.

Biosimilar/Biosimilars

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

Booklet

This document (also called the Benefit Booklet), describes the terms of your benefits while you are enrolled in the Plan.

Centers of Medical Excellence (COE) Network

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

Claims Administrator

The company the Employer chose to administer its health benefits. Anthem Health Plans of Virginia, Inc. was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance after Deductibleon office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments**.**

Consolidated Appropriations Act of 2021

Please refer to “Balance Billing by Out-of-Network Providers” in the “How Your Plan Works” section.

Controlled Substances

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

Copayment

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

Covered 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.

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "What's Covered" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; and (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent

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

Doctor

See the definition of “Physician.”

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the “What’s Covered” section.

Emergency Care

Please see the “What’s Covered” section.

Employee

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

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with the Claims Administrator to administer this Plan.

Excluded Services (Exclusion)

Health care services your Plan doesn’t cover.

Experimental or Investigational (Experimental / Investigational)

Means any service or supply that is judged to be experimental or investigative at Anthem’s sole discretion. Nothing in this exclusion shall prevent a member from appealing Anthem’s decision that a service is experimental / investigative. Services which do not meet each of the following criteria will be excluded from coverage as experimental/investigative:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below.

   There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.
   - This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
     - the following three standard reference compendia defined below:
       - American Hospital Formulary Service – Drug Information
       - National Comprehensive Cancer Network’s Drugs & Biologics Compendium
       - Elsevier Gold Standard’s Clinical Pharmacology

- in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

- In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

2. There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.
3. The available scientific evidence must show a good effect on health outcomes outside a research setting.
4. The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered experimental/investigative.

Facility

A facility means an institution providing health care related services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Fee(s)

The amount you must pay to be covered by this Plan.

Functional Impairment

Limits on normal physical functioning that may include, but are not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts, or obstruction of an orifice. The cause of the physical functional impairment can be due to pain, structural, congenital or other means. Physical functional impairment excludes social, emotional, and psychological impairments or potential impairments.

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 given to you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see “How to Find a Provider in the Network” in the section “How Your Plan Works” for more information on how to find an In-Network Provider for this Plan.

In-Network Transplant Provider

Please see the “What’s Covered” section for details.

Inpatient

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

Intensive In-Home Behavioral Health Program

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

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment for the treatment of alcohol or other drug dependencies 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 for individuals who are not admitted as inpatients.

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.

Maximum Allowed Amount

The allowance as determined by Anthem for a specified covered service or the provider's charge for that service, whichever is less. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

To be considered medically necessary, a service must:

- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of your condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the provider.

Member

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

Mental Health and Substance Use Disorder

Is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a Mental Health and Substance Use Disorder condition.

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 Members under this Plan.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the "What's Covered" section for details.

Out-of-Pocket Limit

The most you (or someone on your behalf to the extent allowed by Federal law and regulation) pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits" for details.

Partial Hospitalization Program

A licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental,

emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of 6 or more continuous hours per day, to individuals or groups of individual who are not admitted as inpatients.

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 (at least annually) 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.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor,
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer's health benefits.

Plan Administrator

The person or entity named by the Plan Sponsor to manage the Plan and answer questions about Plan details. ***The Plan Administrator is not the Claims Administrator.***

Plan Sponsor

The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. ***The Plan Sponsor is not the Claims Administrator.***

Precertification

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

Prescription Drug (Drug)

A substance that under the Federal Food, Drug & Cosmetic Act, must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1) Compounded (combination) medications, when all of the ingredients are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
2) Insulin, diabetic supplies, and syringes.

Prescription Order

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

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan.

Primary Care Providers

A Physician, nurse practitioner, clinical nurse specialist, physician assistant, or any other Provider licensed by law and allowed under the Plan, who gives, directs, or helps you get a range of health care services.

Provider

A professional or Facility licensed 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 (chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist, audiologist, speech pathologist, certified nurse midwife or other nurse practitioner, marriage and family therapist, athletic trainer, or licensed acupuncturist) when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Recovery

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

Referral

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

Residential Treatment Center / Facility:

An Inpatient Facility that 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. For the purposes of offering coverage and determining eligibility, the service area for Anthem is all of Virginia, excluding the City of Fairfax, the Town of Vienna and the area east of State Route 123.

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.

Spouse

Means the Subscriber’s legally married spouse or Domestic Partner.

Subscriber

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

Surprise Billing Claim

Please refer to “Balance Billing by Out-of-Network Providers” in the “How Your Plan Works” section.

Transplant Benefit Period

Please see the “What’s Covered” section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent but non-emergent 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)

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

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa
Ǹ ɓéɖé dyí-ɓɛ̀ɖɛ̀ìn-ɖɛ̀ɔ̀ ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ðá méɓà jè gbo-gmɔ̀ Kpòɛ̀ nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̀ɔ̃ kɔ̃ɛ ɓɛ́ m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

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

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။ (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka
Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tɔ̈ në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d’identification. (TTY/TDD: 711)

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

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

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

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

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

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

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

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo
Bee n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

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

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

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

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

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

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

Romanian

Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

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

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

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

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

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

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

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

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.