Benefit Booklet

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

Anthem Century Preferred PPO $15/$50 Rx $10/$20/$20

Plan Administered by:

Anthem Health Plans, Inc.,
d/b/a Anthem Blue Cross Blue Shield

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

Capital Area Health

07-01-2025

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, except as may be required under any stop loss coverage purchased from Anthem by the employer Group.

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

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

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in our, the Claims Administrator's, network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our, the Claims Administrator's, website, www.anthem.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for obtaining Authorized Services. 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 Mothers 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 Child Support Order (QMCSO) ("QMCSO")

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

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on Mental Health and Substance Use Disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering Mental Health and Substance Use Disorder benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on

Mental Health and Substance Use Disorder benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayments, Coinsurance, and out-of-pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than the predominant Deductibles, Copayments, Coinsurance and out-of-pocket expenses applicable to substantially all medical and surgical benefits in the same classification. Medical Necessity criteria are available upon request.

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, or as noted in "Eligibility and Enrollment – Adding Members".

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 Group.

Statement of ERISA Rights

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

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

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

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan

fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

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

Transparency Requirements

On our website (i.e., www.anthem.com) you can find information regarding the protections provided under the Surprise Billing Claims provisions by Providers, including information on how to contact state and federal agencies if you believe a Provider has violated these protections.

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 covered items, services, and drugs, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all In-Network Providers.

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

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

Introduction

Welcome to Your Plan!

Welcome to your health Plan (the "Plan"), offered by your Employer. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

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

Your 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.

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. The coverage described is based upon the terms of the contract issued to your Employer, and the Plan that your Employer chose for you. The Administrative Services Agreement, this Booklet, and any endorsements, amendments or riders attached, form the entire legal contract under which Covered Services are available. Any group plan or Booklet which you received before will be replaced by this Booklet.

Many words used in the Booklet have special meanings (e.g., Group, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean the Claims Administrator (Anthem) or any of our subsidiaries, affiliates, subcontractors, or designees. 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 our website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

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, except as may be required under any stop loss coverage purchased from Anthem by the employer Group.

How to Get Language Assistance

As Claims Administrator, Anthem is committed to communicating with the Plan's Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written

materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

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What You Pay for Covered Services

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

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

To get the maximum 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. Except for Surprise Billing Claims, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

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

Anthem
Large Group Market
Anthem Century Preferred PPO $15/$50 Rx $10/$20/$20

Schedule of Benefits

This is a brief "Schedule of Benefits" which generally describes the Plan's benefits for Covered Services, and the cost-share(s) you must pay, and where services are usually received. Typically, your benefits and cost-shares are based on the setting in which Covered Services are received (e.g., in a doctor's office, at an outpatient hospital facility, etc.). Please see "Important Notices about Your Benefits and Cost-Shares" for additional information about how your Deductible and Out-of-Pocket works, and other important notices pertaining to your benefits, limits, or cost-shares.

Your Plan provides you with the option to lower your out-of-pocket costs for certain services by going to Site-of-Service Providers or Ambulatory Surgery Centers (Surgical Centers). These Providers may have lower cost-shares and Maximum Allowed Amounts, reducing your Out-of-Pocket costs for certain services. When you use the "Find a Doctor / Find Care" tool on www.anthem.com look for the "Site-of-Service (SOS)" indicator under the "Recognitions(/Tier)" link" to the right of the Provider's name. You can use the "Recognitions" filter function to only select "Site-of-Service" Providers.

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Plan Deductible **Individual** **Family**	Not Applicable	 $200 per Member $600 per Family
Coinsurance After any applicable deductible is met, you may pay Coinsurance for any services not listed in this Schedule.	0% Coinsurance	20% Coinsurance
Out-of-Pocket Limit **Individual** **Family** Includes Deductibles, Copayments and Coinsurance.	 $6,600 per Member $13,200 per Family	 $1,200 per Member $1,600 per Family
Provider Office and Home Visits (In-Person and/or Virtual Visits) Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care Services" row or section in the Booklet.		
Adult / Pediatric Preventive Visit	No Cost-Share	20% Coinsurance after Deductible is met
Travel Vaccines	No Cost-Share	No Cost-Share

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Preventive Care for Chronic Conditions (per IRS guidelines) Includes Medical items, equipment and screenings.	No Cost-Share	20% Coinsurance after Deductible is met
Primary Care Provider Visits (PCP) Includes In-Person and/or Virtual Visits for illness, injury, follow-up care, and consultations.	$15 Copayment per visit **for In-Person Visits** No Cost-Share **for Virtual Visits**	20% Coinsurance after Deductible is met
Specialty Care Provider Visits (SCP) Includes In-Person and/or Virtual Visits.	$20 Copayment per visit **for In-Person Visits** No Cost-Share **for Virtual Visits**	20% Coinsurance after Deductible is met
Mental Health and Substance Use Disorder Provider Visits (MH/SA) Includes In-Person and/or Virtual Visits, Outpatient treatment, and In-Home Behavioral Health Programs.	No Cost-Share **for In-Person Visits** No Cost-Share **for Virtual Visits**	20% Coinsurance after Deductible is met
Retail Health Clinic	$15 Copayment per visit	20% Coinsurance after Deductible is met
Virtual Visits (from Virtual Care Only Providers) You can access Virtual Visits through our mobile app or our website at www.anthem.com.		
Virtual Visits including Primary Care from Virtual Care-Only Providers (Medical Services)	No Cost-Share	Please refer to the "Office and Home Visits" section.
Virtual Visits for Specialty Care Services from Virtual Care-Only Providers	No Cost-Share	Please refer to the "Office and Home Visits" section.
Virtual Visits for Mental Health and Substance Use Disorder Services from Virtual Care-Only Providers	No Cost-Share	Please refer to the "Office and Home Visits" section.
Outpatient Diagnostic Services		
Advanced Radiology Including MRI, CAT, CT, PET Scans, and other diagnostic services.	No Cost-Share **at Site-of-Service Providers** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Laboratory Services	No Cost-Share **at Site-of-Service Providers** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Non-Advanced Radiology Including x-ray, Breast Tomosynthesis, and other diagnostic services.	No Cost-Share **at Site-of-Service Providers** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Prescription Drugs – Retail Pharmacy A 34-day supply per Prescription Drug or Prescription Drug refill at a Retail Pharmacy. Up to a 100-day supply is available at In-Network Maintenance Pharmacies for Tiers 1, 2, and 3, or as noted. When you get a 100-day supply at a Maintenance Pharmacy, up to three (3) Retail Pharmacy Copayments (one for each 34-day period) will apply. **Copayment amounts shown below are based on a 34-day supply per Prescription Drug or Prescription Drug refill**.		
Tier 1 – Typically Generic Prescription Drugs	$10 Copayment per Prescription Drug	20% Coinsurance
Tier 2 – Typically Preferred Brand Name Prescription Drugs	$20 Copayment per Prescription Drug	20% Coinsurance
Tier 3 – Typically Non-Preferred Brand Name and Specialty Prescription Drugs Applies to Brand and Generic Specialty Drugs. Covers up to a 34-day supply of Specialty Drugs.	$20 Copayment per Prescription Drug	20% Coinsurance
Prescription Drugs – Home Delivery (Mail Order) Pharmacy A 100-day supply per Prescription Drug or Prescription Drug refill at an In-Network Pharmacy for Tiers 1, 2, and 3, and a 34-day supply per Prescription Drug or Prescription Drug refill for Specialty Drugs on Tier 3.		
Tier 1 – Typically Generic Prescription Drugs	$0 Copayment per Prescription Drug	Not covered
Tier 2 – Typically Preferred Brand Name Prescription Drugs	$0 Copayment per Prescription Drug	Not covered
Tier 3 – Typically Non-Preferred Brand Name and Specialty Prescription Drugs Applies to Brand and Generic Specialty Drugs. Covers up to a 34-day supply of Specialty Drugs.	$0 Copayment per Prescription Drug	Not covered

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Prescription Drugs – Administered by a Medical Provider Including Specialty Drugs and other drugs and serums for infusion or injection. Does not include Drugs provided while you are inpatient at a Facility.		
Medical Office	No Cost-Share	20% Coinsurance after Deductible is met
Urgent Facility	No Cost-Share	20% Coinsurance after Deductible is met
Outpatient Hospital	No Cost-Share	20% Coinsurance after Deductible is met
Home Health Care Including Specialty Prescription Drugs for infusion / injection, other than Chemotherapy.	No Cost-Share	20% Coinsurance after a $50 Deductible is met
Therapy Services (Outpatient Rehabilitative and Habilitative)		
Physical, Occupational and Speech Therapy Up to 50 visits per calendar year. Limits are combined for physical, speech, and occupational therapy, and manipulative treatment.	No Cost-Share **in an Office** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Other Services		
Chiropractic Care Up to 50 visits for manipulative treatment per calendar year. Limits are combined for physical, speech, and occupational therapy, and manipulative treatment.	No Cost-Share **in an Office** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Diabetic Equipment and Supplies Please note Diabetic supplies are covered under the Pharmacy benefit. Please see that section for details.	No Cost-Share	20% Coinsurance after Deductible is met
Durable Medical Equipment (DME), Medical Devices, and Supplies The cost-shares listed apply when your Provider submits separate bills for the equipment or supplies.	No Cost-Share	20% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Home Health Care Services Up to 200 visits for nursing, (intermittent skilled nursing services), therapeutic, and home health aide services per calendar year provided by a Home Health Care Agency. Home health aide services limited to 80 visits that are applicable to the 200 visit limit.	No Cost-Share	20% Coinsurance after a $50 Deductible is met
Acupuncture Up to 50 visits per calendar year. Coverage is limited for services provided for Pain Management.	No Cost-Share **in an Office** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Allergy Testing	$20 Copayment per visit	20% Coinsurance after Deductible is met
Allergy Treatment Injection, Immunotherapy, or other therapy treatments.	No Cost-Share **in an Office** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Artificial Limbs Includes associated supplies and equipment	No Cost-Share	20% Coinsurance after Deductible is met
Cardiac Rehabilitation Therapy Up to 36 visits per calendar year.	No Cost-Share **in an Office** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Counseling Includes Family Planning and Nutritional Counseling (other than Eating Disorders).	$15 Copayment per visit	20% Coinsurance after Deductible is met
Dialysis and Hemodialysis	No Cost-Share **in an Office** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Home Dialysis, Infusion Therapy, Chemotherapy	No Cost-Share	20% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Hospice Outpatient Services Includes Outpatient Hospice services, Home Hospice services, Bereavement, and Outpatient Respite Care.	No Cost-Share	20% Coinsurance after Deductible is met
Nutritional Counseling for Eating Disorders	$15 Copayment per visit	20% Coinsurance after Deductible is met
Other Therapy Services Including radiation, chemotherapy, respiratory therapy.	No Cost-Share **in an Office** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Prosthetics Including hearing aids and wigs.	No Cost-Share	20% Coinsurance after Deductible is met
Pulmonary Therapy	No Cost-Share **in an Office** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Facility Services		
Outpatient Services Including surgery, infertility, hospice, and diagnostic colonoscopy.	No Cost-Share **at a Surgery Center** No Cost-Share **at an Outpatient Hospital Facility**	20% Coinsurance after Deductible is met
Inpatient Hospital Acute Care Facility Including mental health, substance abuse, maternity, infertility, and Human Organ and Tissue Transplant Services.	No Cost-Share	20% Coinsurance after Deductible is met
Inpatient Rehabilitation Facility Up to 60 days per calendar year.	No Cost-Share	20% Coinsurance after Deductible is met
Partial Hospitalization Program and Intensive Outpatient Program (PHP/IOP) in a Facility For Mental Health and Substance Use Disorder treatment.	No Cost-Share	20% Coinsurance after Deductible is met

Benefit	In-Network (INET) **Participating Providers** Member Pays	**Out-of-Network (OON)** Member Pays
Professional Services A separate professional fee for services performed by Physician or Specialist in any setting other than an Office.	No Cost-Share **at an Outpatient Hospital Facility** No Cost-Share **at an Inpatient Facility** No Cost-Share **at a Mental Health and Substance Use Disorder Inpatient Facility**	20% Coinsurance after Deductible is met
Residential Treatment Center For Mental Health and Substance Use Disorder services.	No Cost-Share	20% Coinsurance after Deductible is met
Skilled Nursing Facility Up to 120 days per calendar year.	No Cost-Share	20% Coinsurance after Deductible is met
Emergency and Urgent Care		
Ambulance Services	No Cost-Share	No Cost-Share
Emergency Room Copayment waived if admitted.	$50 Copayment per visit	$50 Copayment per visit
Urgent Care Services Urgent Care Services may be received in various settings, please refer to those sections of the Schedule for details on what you will pay.	$15 Copayment per visit **at a Walk-In Center** $25 Copayment per visit **at an Urgent Care Facility (Urgent Care Center)**	20% Coinsurance after Deductible is met **at a Walk-In Center** Not covered **at an Urgent Care Facility (Urgent Care Center)**

Important Notices about Your Benefits and Cost-Shares

1. **Applicable Benefit Maximums and Benefit Maximum Notes:** All Benefit Maximum(s) are per Member, are for In- and Out-of-Network visits combined, and are for office and outpatient visits combined. In addition to the Benefit Maximums listed in the "Schedule of Benefits", the following Benefit Maximums and Benefit Maximum Notes also apply:

    a. **Ambulance Services (Non-Emergency):** Coverage is available up to $50,000 per trip for non-Emergency ground or water ambulance services when an Out-of-Network Provider is used. This limit does not apply to air ambulance services.
    b. **Eye Exam:** Coverage is available up to 1 eye exam per Benefit Period.
    c. **Hearing aids:** Coverage is available up to 1 hearing aid or bone-anchored hearing aid per hearing impaired ear every 2 Benefit Periods.
    d. **Home Health Care Services:** Coverage is available up to the amount listed in the "Schedule of Benefits" and the following notes apply:
        - **Home Dialysis and Infusion Therapy:** Dialysis and Infusion Therapy visits are not included in the Home Health Care Services visit maximum.
        - **Medical Social Services:** Coverage is available up to $420 per Benefit Period.
        - **Private Duty Nursing:** Coverage is available up to $15,000 for Private Duty Nursing per Benefit Period provided under the "Home Care Services" benefit.
        - **Therapy Services:** The Home Health Care limit includes Therapy Services (e.g., physical, occupational, or speech therapy, cardiac rehabilitation, or pulmonary rehabilitation) given as part of the Home Health Care Services benefit.
    e. **Human Organ and Tissue Transplant (Bone Marrow / Stem Cell / Cord Blood) Services:**
        - **Donor Search Limit:** Coverage is available up to the 10 best matched donors, identified by an authorized, licensed registry.
        - **Transportation and Lodging Limit:** Coverage is available, as approved by us, up to $10,000 per transplant for transportation and Lodging when receiving services at a Center of Excellence (COE) Transplant Provider. Subject to travel per diem rules and distance radius requirements.
    f. **Therapy Services (Outpatient Rehabilitative and Habilitative):**
        - The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.
        - When you get Therapy Services in the home, the Home Health Care Services limit will apply instead of the applicable Therapy Services visit limit.
        - Any limits for physical, occupational, and speech therapy will not apply to services.
    g. **Wigs:** Coverage is available up to 1 wig for hair loss after Cancer treatment per Benefit Period.

2. **Benefit Period:** The Benefit Period for this Plan is Calendar Year. Please see "Definitions" for details.

3. **Deductible Notes:**

    a. When the Deductible applies, you must pay it before benefits begin. Please see the "Schedule of Benefits" to find out when the Deductible applies.
    b. Your Plan has two types of Deductible, the individual and family Deductibles. If you are the only person on your plan, then the individual Deductible applies. If your plan includes you and other family members then both types of Deductibles may apply to you. When anyone on the plan has a health care expense, the money you pay toward the Deductible is credited to both the individual and family Deductibles. The Deductible is considered satisfied for any one member when an individual satisfies his or her individual deductible, prior to receiving benefits that are subject to the deductible. The Plan also begins to pay benefits that are subject to the deductible for the entire family, when the amounts collectively paid by everyone in the family meet the family deductible, even if none of the family members has met the individual deductible.
    c. Copayments and Coinsurance are separate from and do not apply to the Deductible.

d. This Plan has a separate Home Health Care Deductible, and it does not apply toward any other Deductible for Covered Services in this Plan.
e. The In-Network and Out-of-Network Deductibles are separate and do not accumulate towards each other.

4. **Coinsurance 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.

5. **Out-of-Pocket Limit Notes:**

a. The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period, unless otherwise indicated below. The Out-of-Pocket Limit does not include:
   - Charges over the Maximum Allowed Amount.
   - Amounts you pay for non-Covered Services.
   - Services listed under Out-of-Network Human Organ and Tissue Transplant (Bone Marrow / Stem Cell, Cord Blood), Cellular and Gene Therapy Services.

b. The Out-of-Pocket Limit does not include amounts you pay for Services listed under Out-of-Network Human Organ and Tissue Transplant services.
c. 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.
d. Your Plan has two types of Out-of-Pocket Limit, the individual and family Out-of-Pocket Limits. If you are the only person on your plan, then the individual Out-of-Pocket Limit applies. If your plan includes you and other family members then both types of Out-of-Pocket Limits may apply to you. When anyone on the plan has a health care expense, the money you pay toward the Out-of-Pocket Limit is credited to both the individual and family Out-of-Pocket Limits. The Out-of-Pocket Limit is considered satisfied for any one member when he or she satisfies his or her individual Out-of-Pocket. The Out-of-Pocket Limit is considered satisfied for the family when the amounts collectively paid by everyone in the family meets the family Out-of-Pocket Limit. Together each family member may contribute to the family Out-of-Pocket Limit, but no family member will contribute more than their individual Out-of-Pocket Limit, and other family members may not need to contribute at all towards the Out-of-Pocket Limit.
e. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not accumulate towards each other.

6. **Mental Health and Substance Use Disorder Office Provider Visits:** Includes Office Visits, Virtual Visits, Outpatient treatment, Partial Hospitalization and Intensive Outpatient Programs in an office setting, and in Home treatment.

7. **Office Visit Notes:**

a. **Primary Care Physician / Provider (PCP) Requirement:** Each Member must pick a PCP for routine physicals and to help when you are ill or need follow-up care. A referral from your PCP is not required. Please see "How Your Plan Works" for more details.
b. If you have an office visit with your Primary Care Physician / Provider (PCP) or Specialist (SCP) at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center (Surgical Center)), benefits for Covered Services will be paid under the "Facility Services" section as shown in the "Schedule of Benefits". Please refer to that section in the "Schedule of Benefits" for details on the cost-share (e.g., Deductibles, Copayments, Coinsurance) that will apply.
c. When "See PCP / SCP Copayment" appears in your "Schedule of Benefits" your Copayment will depend on if the provider is a Primary Care Physician / Provider (PCP) or Specialty Care Physician / Provider (SCP). Please see the PCP and SCP rows for the Copayment that applies to each Provider.

8. **Out-of-Network Reminder:** Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.

9. 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.

10. Some services must be approved through prior authorization or precertification. Please see "Getting Approval for Benefits" for details.

11. **Inpatient Services:**

    a. **Admission from ER:** If you are admitted directly to the Hospital from the emergency room the Emergency Room Copayment will be waived and your Inpatient Cost-Share applied.
    b. **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.

12. **Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits**

    a. Each Prescription Drug will be subject to a cost-share (e.g., Copayment / Coinsurance) as described in the "Schedule of Benefits". If your Prescription order includes more than one Prescription Drug, a separate cost-share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost-share or the Maximum Allowed Amount.
    b. Prescription Drugs that we are required to cover by federal law under the "Preventive Care" benefit will be covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.
    c. Diabetic Treatment**:** For the Medically Necessary prevention or treatment of diabetes or low blood sugar, Connecticut State Mandate requires the per Member Cost-Share limit for each 30-day supply of:
        - an insulin drug and/or non-insulin glucagon drug to not exceed $25 per prescription, and
        - covered diabetic devices and diabetic ketoacidosis devices prescribed for a 30-day period may not exceed $100. This may include blood glucose test strips, lancet, and/or insulin syringe. Long lasting devices such as glucometer, continuous glucose monitor, lancing device, and insulin pumps are not included in this limit.

    When you get a 90-day supply, three (3) 30-day Cost-Share limits (one for each 30-day period) will apply.

13. **Preventive Services:**

    a. You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's websites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.
    b. If Preventive Care is provided during a Virtual Visit, it will be covered under the "Preventive Care" benefit, as required by law.

How Your Plan Works

Introduction

Your Plan is a PPO plan. This Plan has In-Network and Out-of-Network benefits. 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.

Where You Can Get Services

Your Plan has different levels of coverage depending on the Providers you use.

Site-of-Service In-Network Providers. When you go to a Site-of-Service In-Network Provider, you pay a lower Cost-Share on certain Covered Services than when you go to other In-Network Providers. Site-of-Service (SOS) providers include labs, radiology and diagnostic imaging centers.

In-Network Providers. When you go to an In-Network Provider, you will pay the applicable Cost-Shares for Covered Services as outlined on Your "Schedule of Benefits". In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers – SCPs), other professional Providers, Hospitals, and other Facilities who contract with us to care for you.

Out-of-Network Providers. When you go to an Out-of-Network Provider, you will pay the highest Cost-Shares because these Providers are not in our network.

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. 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 a Grievance as outlined in the "Grievance Review Procedures" section of this Booklet.

Selecting a Primary Care Physician / Provider (PCP)

It is recommend that you select a Primary Care Physician / Provider (PCP) from our network. PCPs include internists, family/general practitioners, pediatricians, geriatricians, and Advanced Practice Registered Nurse (APRN). Each Member should choose a PCP who is listed in the Provider directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, contact us or see our website, www.anthem.com.

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

First – Make an Appointment with Your PCP

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

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

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

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

When you meet with your Provider, be sure to have your Member ID Card available.

If you need to see a Specialist, you can visit any In-Network Specialist including a behavioral health Provider. You do not have to get a referral.

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

In-Network Providers

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

To see a Doctor, contact their office:

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

When you go to the office, be sure to bring your Member Identification Card with you.

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.

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 applicable Cost-Shares unless your claim involves a Surprise Billing Claim;

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

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

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

5. You may have to file claims; and

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

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.

  This directory is an interactive tool that helps you locate Providers based on Provider type, specialty, and location. It will also identify if is a Site-of-Service Provider. This information will appear under the "recognitions(/Tier)" link by the Physician or Facility name. You can use the "Recognitions" filter function to only select Site-of-Service Providers.

- 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. Member Services can help you determine the Provider's name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.
- Check with your Doctor or Provider.

In most cases, there will be a Provider in our Network to treat your specific illness or injury. If there is no In-Network Provider who is qualified to perform the treatment You require, contact Us prior to receiving the service or treatment, and We may approve an Out-of-Network Provider for that service as an Authorized Service.

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

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.

Enhanced Personal Health Care Program

Certain Primary Care Providers are part of our Enhanced Personal Health Care Program, a program aimed at improving the quality of our Members' health care. Providers in this program agree to coordinate much of your care and will prepare care plans for Members who have multiple, complex health conditions.

Providers in this program have met certain quality requirements, including standards from the National Committee on Quality Assurance, the American Diabetes Association, the American Academy of Pediatrics, and others. We encourage you to use these Providers whenever possible.

Continuity of Care

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

- An ongoing course of treatment for a life-threatening condition, including a chronic illness or condition. A chronic illness or condition is a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time,
- An ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy and post-operative visits),
- An ongoing course of treatment for pregnancy and through the postpartum period, or
- A scheduled non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such a surgery, or
- 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, or

- Continuing care benefits for Members undergoing a course of institutional or Inpatient care from the Provider or Facility and/or determined to be terminally ill and is receiving treatment for such illness from such Provider or Facility.

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

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

Your Cost-Shares

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

The BlueCard Program

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

Identification Card (ID Card)

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

Getting Approval for Benefits

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

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

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

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

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination, which is done before the service or treatment begins or admission date.

- **Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

  For admissions following Emergency Care, you, your authorized representative or Doctor must tell us of the admission as soon as possible. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

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

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

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

Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

As required by law, if a Precertification or Continued Stay / Concurrent Review is requested, we will notify you or, if applicable, the Provider of the Network status of the Provider performing Covered Services. In certain circumstances if we fail to notify you that a Provider is Out-of-Network, In-Network cost-shares may apply.

Reviewing Where Services Are Provided

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

Examples include, but are not limited to:

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

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

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

Provider Network Status	Responsibility to Get Precertification	Comments
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.**
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, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section “Prescription Drugs Administered by a Medical Provider”. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. As Claims Administrator, we reserve the right, on behalf of the Group, 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 “Grievance Review Procedures” section to see what rights may be available to you.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on 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
Request for Medical Services	

Urgent Pre-service Review	48 hours from the receipt of request, or 72 hours from receipt of request if any portion of 48 hours period falls on a weekend
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	48 hours from the receipt of the request, or 72 hours from receipt of request if any portion of 48 hours period falls on a weekend
Non-urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request
Request for Mental Health and Substance Use Disorder Services	
Urgent Pre-service Review – Levels of care include: Inpatient Services, Residential Treatment, Partial Hospitalization, or Intensive Outpatient Programs.	24 hours from the receipt of the request
Non-Urgent Pre-service Review – Outpatient Services	15 calendar days from the receipt of the request
Urgent Continued Stay / Concurrent Review	24 hours from the receipt of the request
Non-urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

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

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

Important Information

On behalf of the Group, 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 contacting the Member Services number on the back of your ID card.

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

Health Plan Individual Case Management

We have a range of programs designed to provide and/or help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions (the "Program(s)"). Our Programs provide certain services, coordinate benefits and/or educate Members who agree to take part in them to help meet their health-related needs.

Our 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 Anthem and 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, as appropriate, 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 decision or recommendation for alternate or extended benefits to the Plan on a case-by-case basis, if we determine the alternate or extended benefit is in the best interest of you and the Plan, and you or your authorized representative agree to all Program requirements 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.

CareMore Health Program

You may qualify to receive health care services offered by CareMore Medical Group of Connecticut (CareMore), an Anthem Network Provider. CareMore is a team of health care professionals consisting of

physicians, nurse practitioners, medical assistants, case managers and social workers who provide care for qualified Anthem Members in their own home or at a CareMore Care Center.

CareMore is a voluntary program through which qualified Members can receive care coordination and comprehensive primary care services for a number of complex medical conditions, including diabetes, congestive heart failure, chronic obstructive pulmonary disease and chronic kidney disease. Once enrolled in the program, the CareMore care team works with Members and their PCP to deliver comprehensive primary care that may help them achieve their best state of health.

You may be contacted by CareMore about joining the program or you may apply for admission to the program by calling Member Services. To be eligible for enrollment in CareMore you must meet the program requirements. Following an evaluation and assessment, CareMore will determine whether the program is a good fit for your needs and begin the enrollment process.

What's Covered

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

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

You should also know that many of Covered Services can be received in several settings, including a Doctor's office or your home, a Walk-In Center, 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 Services

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. 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.

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.

Covered Services include Medically Necessary transportation and treatment of a sickness or injury by medical professionals from an ambulance service. The ambulance service medical professionals will transport you to the emergency facility best suited to provide you care at the time of services, regardless if they are In- or Out-of-Network. Benefits also includes treatment onsite of the sickness or injury, 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 preference or convenience, or the preference or 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 Doctor's office or clinic;
- To a morgue or funeral home;
- To Elective Hospital Admissions;
- In Wheelchair vans, ambulettes, or medical cabs.

Please see the "Important Notices about Your Benefits and Cost Shares" for the maximum benefit.

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.

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,

For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment.

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

Please see “Therapy Services” later in this section.

Behavioral Health Services

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

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

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. In any of the following 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.

- The Department of Veterans Affairs.
- The Department of Defense.
- 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. The Plan reserves the right to exclude any of the following services:

1. The Investigational item, device, or service;

2. 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;

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Routine Patient Care Costs in connection with Clinical Trials shall include Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Such services shall include those rendered by a Physician, diagnostic or laboratory tests, hospitalization, or other services provided to the Member during the course of treatment in Clinical Trial and Coverage for Routine Patient Care Costs incurred for off-label drug prescriptions in accordance with Connecticut Law. Hospitalization shall, for Routine Patient Care Costs, include treatment at an Out-of-Network facility if such treatment is not available In-Network and not eligible for reimbursement by the

sponsors of such clinical trial; Out-of-Network Hospitalization will be rendered at no greater cost-share to the insured person than if such treatment was available In-Network, all applicable In-Network cost-shares will apply.

Routine Patient Care Costs shall not include:

1. The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration;

2. The cost of a non-health care service that an insured person may be required to receive as a result of the treatment being provided for the purposes of the Clinical Trial;

3. Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Clinical Trial;

4. Costs of services that (A) are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or (B) are performed specifically to meet the requirements of the Clinical Trial;

5. Costs that would not be covered under this Plan for non-investigational treatments, including items excluded from coverage under the Plan; and

6. Transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Clinical Trial, for the insured person or any family member or companion.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

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

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

Treatment of Accidental Injury

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

Medically Necessary Hospital Dental Services

Your Plan also includes Medically Necessary coverage for anesthesia, nursing, and other related hospital services for inpatient or outpatient hospital dental services, or one day dental services when the treating dentist, oral surgeon and your Primary Care Provider determine the dental services to be Medically Necessary and:

- You have a dental condition complex enough that it requires Inpatient services, Outpatient hospital dental services, or one day dental services; or
- You have a developmental disability that places you at serious risk.

All services must be authorized by us as outlined in the “Getting Approval for Benefits” section.

Diabetes Equipment, Education, and Supplies

Your Plan includes coverage for diabetic drugs, supplies and equipment. Generally, these services are covered under your “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit. However, Insulin pumps and supplies are covered under your “Durable Medical Equipment (DME), Medical Devices, and Supplies” benefit. You may call Member Services at the number on your Identification Card for more information.

Outpatient self-management training for the treatment of diabetes is covered if: prescribed by a licensed health care professional; and performed by: a certified; licensed; or registered health care professional trained in diabetes care; and operating within the scope of their license. Benefits are provided for: 10 hours of initial training; 4 hours of extra training because of changes in the person’s condition; and 4 hours of training required by new developments in the treatment of diabetes.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

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

Non-Advanced Radiology – Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Radiology – Diagnostic Imaging Services

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

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)

- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QCT Bone Densitometry
- Diagnostic CT Colonography

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

Other Diagnostic Services

Benefits include, but are not limited to:

- Blood lead screenings and clinically indicated risk assessments.
- Sleep Studies – 1 complete Sleep Study per lifetime.
- Neuropsychological Testing – Psychological, neuropsychological, and neurobehavioral testing.

Dialysis

Please see “Therapy Services” later in this section.

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

The cost-shares listed in the “Schedule of Benefits” only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.

The Plan’s reimbursement for durable medical equipment, orthotics, prosthetics, artificial limbs, devices and supplies, hearing aids and wigs will be based on the Maximum Allowed Amount for a standard item that is Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and you will be required to pay any costs that exceed the Maximum Allowed Amount. Please check with your Provider or contact us if you have questions about the Maximum Allowed Amount.

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, purchase or rent-to-purchase equipment and devices, and continuous rental equipment and devices. Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

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

Oxygen and equipment for its administration are also Covered Services.

Orthotics

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

Prosthetics

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

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

- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes.
- Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).
- Wigs needed after cancer treatment.
- Cochlear implants.
- Hearing aids to aid or compensate Members who are certified as deaf or hearing impaired by either a Doctor or licensed audiologist. This includes bone-anchored hearing aids as well as FDA-approved over-the-counter hearing aids.

Artificial Limbs

Your Plan includes benefits for Artificial Limbs and accessories, including a Medically Necessary device that contains a microprocessor and repairs and replacements. Artificial Limbs are devices to replace, in whole or in part, an arm or a leg when they are Medically Necessary for activities of daily living.

Services must be authorized by us as outlined in the "Getting Approval for Benefits" section. See the "Schedule of Benefits" for any applicable Cost-Shares.

Covered Services do not include:

- Artificial Limbs designed exclusively for athletic purposes.
- Repair or replacement due to misuse or loss.
- Back-up items or items that serve a duplicate purpose.

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.

Benefits include wound-care supplies that are Medically Necessary for the treatment of epidermolysis bullosa and are administered under the direction of a Doctor.

Covered Services do not include items often stocked in the home for general use (e.g. Band-Aids, thermometers, and petroleum jelly) and multi-purpose items that could be used for non-medical reasons (e.g. Tape, surgical gloves, batteries, battery chargers, and cleansing agents).

Blood and Blood Products

Your Plan also includes coverage for the administration of blood.

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 freestanding Emergency Facility for services and supplies to treat the onset of symptoms for an Emergency, which is defined below. **Services provided for conditions that do not meet the definition of Emergency may not be covered.**

Emergency (Emergency Medical Condition)

“Emergency,” or “Emergency Medical Condition” means 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 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) 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 exam done in the Emergency Department of a Hospital or freestanding Emergency Facility, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient. Emergency Care may also include necessary services, including observation services, provided as part of the Emergency visit regardless of the department in which the services are provided.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification, only until your condition is stable. This means you have been provided necessary Emergency Care such that your condition will not materially worsen, and you are able to travel to an In-Network Facility. While under Emergency Care, the Out-of-Network Provider can only charge you any applicable cost-shares (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, as required under Surprise Billing Claims.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you may have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, as well as any applicable Cost-Shares.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined as outlined in the "Claims Payment" section of this Booklet.

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.

Gene Therapy Services

Your Plan includes benefits for gene therapy services, when the benefits are approved in advance through Precertification. See "Getting Approval for Benefits" for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call us to find out which providers are approved Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.)

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

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

Gender Affirming Services

This Plan provides benefits for gender affirming services, including gender affirming surgery and hormone treatments, for Members diagnosed with Gender Dysphoria. To be eligible for benefits, services must be Medically Necessary and all inpatient Facility admissions must be approved in advance through Precertification. Please refer to the "Getting Approval for Benefits" section for further details.

Details on our medical policies are also available online at www.anthem.com/provider/policies/clinical-guidelines/.

Habilitative Services

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

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

Home Health Care Services

Benefits are available for Medically Necessary 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, Physician assistant, or an Advanced Practice Registered Nurse (APRN) 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 by a licensed health care professional 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.
- Private duty nursing services.

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.

Custodial Care, convalescent care, domiciliary care and rest home care are not home health services benefits under this Plan.

Home Infusion Therapy

Please see “Therapy Services” later in this section.

Hospice Care

You are eligible for hospice care if your Doctor, Physician assistant, or Advanced Practice Registered Nurse (APRN) and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing

disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated caregiver and individuals with significant personal ties, for one year after the Member's death.

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

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

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

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Cost-shares for the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received.

Certain services (e.g., cornea and ventricular assist devices) 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.**

Covered Transplant Procedure

As decided by us, any Medically Necessary human solid organ, tissue, and bone marrow / stem cell / cord blood 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.

Please note 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 / cord blood is included in the Covered Transplant Procedure benefit regardless of the date of service.

Centers of Excellence (COE) Transplant Providers

Centers of Excellence (COE) Transplant Providers include facilities with the following designations for transplants;

- **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 has been designated as a Center of Excellence. 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.

To get the most benefits under your Plan, you must get certain human organ and tissue transplant services from an In-Network Transplant Provider. 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).

Out-of-Network Transplant Provider

Any Provider that has **NOT** been designated as a Center of Excellence for Transplants. When you use an Out-of-Network Transplant Providers benefits will be covered at the Out-of-Network level.

When you chose an Out-of-Network Transplant Provider:

- If the Out-of-Network Transplant 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.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period for a Covered Transplant Procedure starts one day before a solid organ transplant 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 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.

Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.

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 the Plan gives 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, on behalf of the Group, 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. Please see the “Getting Approval for Benefits” section for how to obtain Precertification.

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 requested transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Services

Live Donor Health Service

Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. A live donor is a person who provides the organ, part of an organ, or tissue for transplantation while alive to another person.

Donor Searches

Your Plan includes one Human Leukocyte Antigen (HLA) testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens, for use in bone marrow transplantation per lifetime. The

testing must be done at an accredited facility and at the time of testing you must sign a consent form authorizing the results of the testing to be used in the national Marrow Donor Program.

Unrelated donor searches from an authorized, licensed registry for bone marrow / stem cell / cord blood transplants for a Covered Transplant Procedure are covered by when approved through Precertification as described above. Donor search charges are limited to the 10 best matched donors, identified by an authorized, licensed registry.

Transportation and Lodging

When you use a Center of Excellence In-Network Transplant Provider we will cover, on behalf of the Group, the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 300 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. Please see the “Important Notices about Your Benefits and Cost-Shares” for the maximum benefit.

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, casts, and splints.
- Diagnostic services.
- Therapy services.
- Treatment for ingestion and accidental consumption of a controlled drug or other substance.

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.

***Note:** 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 Hospital Acute Care Facility" will apply. Inpatient Services in the home are for acute services that require higher levels of care and monitoring and regular contact with care providers

from the hospital staff. They are not the same as Home Health Care Services. For Home Health Care benefits please see the "Home Health Care Services" section.

Maternity and Reproductive Health Services

Maternity Services

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

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services (Benefits for services for Members who have current symptoms or a diagnosed health problem may be billed in addition to the global fee (e.g., for additional ultrasounds during a high-risk pregnancy) under the "Diagnostic Services" benefit, and may be subject to additional Cost-Shares, based on the setting in which Covered Services are received.); and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

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

Important Note About Maternity Admissions: Under federal law, 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. Should a mother and newborn be discharged earlier than the 48 hours, or 96 hours, as applicable, coverage will include a follow-up visit within 48 hours of discharge and an additional follow-up visit within 7 days of discharge. 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 oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

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

Abortion Services

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

Under Federal law the Hyde Amendment blocks federal funds from being used to pay for abortion outside of the exceptions for rape, incest, or if the pregnancy is determined to endanger the woman's life.

Infertility Services

Infertility services are the Medically Necessary expenses of the diagnosis and treatment of infertility. Effective 7/1/2022, covered services related to infertility must be rendered by a Connecticut participating provider. Infertility services performed by any provider other than a participating provider located within Connecticut are considered non-covered services.

Infertility services are the medically necessary expenses for the diagnosis and treatment of infertility. While not all forms of infertility treatment are covered, some services covered under the plan include:

- Diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis.
- Services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).
- Covered Services also include Ovulation induction, Intrauterine insemination, in-vitro fertilization, GIFT (gamete intrafallopian transfer), or ZIFT (zygote intra-fallopian transfer), and low tubal ovum transfer.

Please note: Fertility preservation services are not covered under this plan. This includes elective egg or sperm cryopreservation. Exceptions may apply if required by law for medically necessary fertility preservation, such as prior to cancer treatments.

Mental Health and Substance Use Disorder Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, detoxification, and stabilization services.

- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment, such as detoxification and stabilization services, and includes:

    - Observation and assessment by a physician weekly or more often,
    - Rehabilitation and therapy.

    Benefits for confinement in a Residential Treatment Facility shall be provided only in the following situations:

    – the insured has a Medically Necessary, serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a physician,

psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting; and
  - An individual Treatment Plan must be prescribed by a Physician with certain specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

- **Outpatient Services** including office visits, therapy, treatment, evidence-based maternal, infant and early childhood home visitation services, detoxification and stabilization services, chemical maintenance treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs, Intensive In-Home Behavioral Health Services, Home-based or evidence-based therapeutic interventions for children and adolescents, extended day treatments, and Observation beds in an acute hospital setting.

  Outpatient care for mental illness includes services rendered in the following locations: a non-profit community mental health center, an urgent crisis center, a non-profit licensed adult mental health center, a non-profit licensed adult psychiatric clinic operated by an accredited Hospital or in a Residential Treatment Facility when provided by or under the supervision of a Physician practicing as a psychiatrist, licensed psychologist, licensed clinical Social Worker, licensed Marriage and Family Therapist or a l-Licensed or certified Alcohol and Drug Counselor; or appropriately licensed professional counselor or licensed Advanced Practice Registered nurse.

  Outpatient care for mental illness includes services by a person with a master's degree in social work when such person renders service in a child guidance clinic or in a Residential Treatment Facility under the supervision of a Physician practicing as a psychiatrist, licensed psychologist, licensed clinical Social Worker, licensed Marriage and Family Therapist or a licensed or certified Alcohol and Drug Counselor or appropriately licensed professional counselor or licensed Advanced Practice Registered nurse.

- **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.),
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed or Certified Alcohol and Drug Counselor,
- Licensed professional counselor (L.P.C),
- Licensed Advanced Practice Registered nurse (A.P.R.N.), or
- Any agency licensed to give these services, when they must be covered by law.

The Facility must be licensed as required by law, satisfy our accreditation requirements, and is approved by us (Anthem).

Mental health Care does not include:

- intellectual disabilities,
- specific learning disorders,
- motor disorders,
- communication disorders,
- caffeine-related disorders,
- relational problems, and
- other conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".

Occupational Therapy

Please see “Therapy Services” later in this section.

Office and Home Visits

Covered Services include:

- **Office Visits** for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.
- **Consultations** between your Primary Care Physician and a Specialist, when approved by Anthem.
- **Home Visits** for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor and Primary Care Provider visits in the home are different than the “Home Health Care Services” benefit described earlier in this Booklet.
- **Retail Health Clinic Care** for limited basic health care services to Members without an appointment. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.
- **Walk-In Doctor’s Office** for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor’s office.
- **Walk-In Center Care** for evaluation and treatment of Urgent Care services, routine care, or common illnesses for adults and children on a “walk-in” basis. Please see “Urgent Care Services” later in this section for more details**.**
- **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 (Surgical Center),
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

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

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services,
- Treatment for ingestion and accidental consumption of a controlled drug or other substance.

Pain Management

Medically Necessary Pain Management medications and procedures when ordered by a pain management specialist.

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:

    - Breast cancer,
    - Cervical cancer,
    - Colorectal cancer - This includes the preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. It also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e., flexible sigmoidoscopy, CT colonography),
    - High blood pressure,
    - Type 2 Diabetes Mellitus,
    - Cholesterol,
    - Child and adult obesity.

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

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

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

    - Women's contraceptives, sterilization treatments, and counseling. This includes Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. Some categories and classes of contraceptives do not have Generics available and, in each of these categories, at least one Brand Drug is available at no cost-sharing when you receive it from an In-Network Provider. If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent is Medically Necessary because a Generic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Drug with no cost-sharing if your Provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. You or your Doctor can find the form online at https://file.anthem.com/Anthem_ABS_BrandContraceptiveCopayWaiverForm.pdf or by calling the number listed on the back of your ID Card. If Medical Necessity has been determined by your Provider, an exception will be granted and coverage of the Drug will be provided at no cost-sharing. Otherwise, Brand Drugs will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

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

    - Screenings and/or counseling, where applicable, including but not limited to; Gestational diabetes, Human Papillomavirus (HPV), sexually transmitted infections (STIs), Human immune-deficiency virus (HIV), and interpersonal and domestic violence.

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

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including, but not limited to:

    - Aspirin
    - Folic acid supplement
    - Bowel preparations
    - FDA-approved preexposure prophylaxis (PrEP), related services and monitoring including follow-up HIV testing and additional testing to monitor the effects of the PrEP medications.

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

7. Additional screenings and services to monitor for breast cancer and other gynecological cancers may be considered preventive care services under state law.

These may be available to you, if you are believed to be at an increased risk due to:

- A family history, or
- A prior personal history of breast, ovarian, or certain related cancers, or
- If the treatment of a childhood cancer has increased your risk of breast cancer, or
- A positive genetic test for gene variants that increase your risk to certain cancers, or
- Other indications as determined by the insured's physician, advanced practice registered nurse, physician assistant, certified nurse midwife or other medical provider.

Requirements for each screening or service may vary and may be subject to Medical Necessity review.

Diagnostic and screenings services may include, but may not be limited to:

- Mammograms, including mammograms provided by Breast Tomosynthesis (3D).
- Comprehensive Ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology.
- Magnetic Resonance Imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.
- Mastectomies intended to prevent disease (prophylactic mastectomy).
- Genetic Testing.
- Routine screening procedures and surveillance tests for ovarian cancer.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's websites, 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, freestanding Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

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

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

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

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Smoking Cessation

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

Specialized Formula and Modified Foods

Specialized Formula is a nutritional formula for children that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the Federal Food and Drug Administration.

Coverage for Specialized Formula is intended for use of dietary management of specific disease when under the medical direction and supervision of a doctor, when such specialized formulas are medically necessary for the treatment of that disease or condition.

Benefits also include Amino acid modified preparations; and low protein modified food products for the treatment of inherited metabolic diseases and cystic fibrosis.

All services must be authorized by us as outlined in the “Getting Approval for Benefits” section.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

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

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

Bariatric Surgery

Benefits include coverage for any Medically Necessary Bariatric surgery procedure.

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, ectodermal dysplasia, or other complex craniofacial disorder.
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services (All Members / All Ages)” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.
- Treatment of fractures of the jaw and/or facial bones, and dislocation of the jaw.

Reconstructive Surgery

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

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

Reconstructive surgeries, procedures and services:

Benefits are available for Medically Necessary reconstructive surgeries, procedures and services only if at least one of the following criteria is met. Reconstructive surgeries, procedures and services must be:

- Medically Necessary due to accidental injury; or
- Medically Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
- Medically Necessary to restore or improve a bodily function; or
- Medically Necessary to correct a birth defect for covered dependent children who have functional physical deficits due to a birth defect. Corrective surgery for children who do not have functional physical deficits due to a birth defect is not covered under any portion of this Booklet; or
- Medically Necessary due to a mastectomy in accordance with the Women's Health and Cancer Rights Act of 1998 (see below).

Reconstructive surgeries, procedures and services that do not meet at least one of the above criteria are not covered under any portion of this Plan.

In addition to the above criteria, benefits are available for certain reconstructive surgeries, procedures and services subject to Anthem Medical Policy coverage criteria. Some examples of reconstructive surgeries, procedures, and services eligible for consideration based on Anthem Medical Policy coverage criteria are:

- Mastectomy for Gynecomastia;
- Mandibular/Maxillary orthognathic surgery;
- Adjustable Band for Treatment of Non-synostotic plagiocephaly and Brachycephaly in infants and
- Port Wine Stain surgery.

Breast Implant Removal Notice

For breast implants which were surgically implanted as a result of a mastectomy, benefits for Covered Services for the Medically Necessary removal of such implants due to a medical complication of a mastectomy will be covered the same as any other illness or injury. As to all other breast implants, benefits for Covered Services for the Medically Necessary removal of any breast implant without regard to the reason for implantation will be provided.

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.

Therapy Services

Please see the "Schedule of Benefits" and "Important Notices about Your Benefits and Cost-Shares" under Therapy Services (Outpatient Rehabilitative and Habilitative Services) for Cost-Shares and Benefit Limits.

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.

- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.

- **Post-cochlear implant aural therapy –** Services to help a person understand the new sounds they hear after getting a cochlear implant.

- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.

- **Chiropractic / Osteopathic / Manipulation 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.

Early Intervention Services

Medically Necessary early intervention services are available for eligible children as defined by law. Generally, this includes children from birth to thirty-six months of age who are either experiencing a significant developmental delay or likely to experience one due to a physical or mental condition. Covered Services are provided for a Member and their family members under an individualized family service plan.

Autism Services

Coverage shall be provided for the Medically Necessary diagnosis and treatment of Autism Spectrum Disorders (ASDs) based on an approved treatment plan. Your treatment plan will be reviewed not more than once every six months unless your licensed Physician, licensed psychologist or licensed clinical social worker agrees that a more frequent review is necessary or as a result of changes in your treatment plan.

Covered Services include:

- Behavior Therapy rendered by an Autism Behavioral Therapy Provider and ordered by a licensed physician, psychologist or clinical social worker in accordance with a treatment plan developed by a licensed Physician, psychologist or licensed clinical social worker;
- Prescription drugs prescribed by a licensed Physician, advanced practiced registered nurse, or licensed physician assistant for the treatment of symptoms and co-morbidities of autism spectrum disorders;
- Direct psychiatric or consultative services provided by a licensed psychiatrist or psychologist;
- Occupational, Physical, and Speech therapy provided by a licensed therapist.

There is no coverage for special education and related services, except as described above.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.

- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section “Prescription Drugs Administered by a Medical Provider” for more details.

- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.

- **Infusion Therapy –** Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). 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 –** Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.

- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.

- **Respiratory 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.

- **Intravenous and oral antibiotic therapy for the treatment of Lyme Disease.** Coverage is provided for up to 30 days of intravenous antibiotic therapy, or 60 days of oral antibiotic therapy, or both, for the treatment of Lyme Disease. Further treatment is covered if recommended by a board-certified rheumatologist, infectious disease Specialist or neurologist.

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. When that happens you can visit your local Walk-In Center or Urgent Care Facility (Urgent Care Center). Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

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

Virtual Visits (Telemedicine / Telehealth Visits)

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

- “Telemedicine / Telehealth” means the delivery of health care or other health services using electronic communications and information technology as defined under Connecticut state law, including: live (synchronous) secure videoconferencing or secure instant messaging; 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, texting, 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)

IMPORTANT: If you opt to receive optometric services or procedures that are not covered benefits under this plan, a participating optometrist may charge you his or her usual and customary rate for such services or procedures. Prior to providing you with optometric services or procedures that are not covered benefits, the optometrist should provide you with a treatment plan that includes each anticipated service or procedure to be provided and the estimated cost of each such service or procedure. To fully understand your coverage, you may wish to review your evidence of coverage document.

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. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important Details About Prescription Drug Coverage

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

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

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, 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),
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Some or all of these drug edits may apply to your plan, please call "Member Services" if you have any questions.

Covered Prescription Drugs

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

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

Precertification

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

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

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

If precertification is denied you have the right to file a Grievance as outlined in the “Grievance Review Procedures” 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 us. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

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

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

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

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

Therapeutic Equivalents

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

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

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

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

Prescription Drug Benefits

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

Prior Authorization

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

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

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

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in our sole discretion, such change furthers the provision of cost effective, value based and/or quality services. Such changes are subject to the terms and conditions provided in this Booklet.

If prior authorization is denied you have the right to file a Grievance as outlined in the "Grievance Review Procedures" section of this Booklet.

In addition, any drug that falls into one of the following categories will also require Prior Authorization:

- any drug that is not on the Prescription Drug list, or
- any drug that is newly available to the market, or
- any drug with new indications and/or dosage forms.

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy.
- Specialty Drugs.
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Self-injectable insulin and supplies and equipment used to administer insulin.
- Continuous glucose monitoring systems and supplies.
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- Flu Shots (including administration). These will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.
- Compound ingredients within compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Prescription Drugs used to treat infertility.

A separate Cost-Share applies for each Drug, supply, or component/item. If your Prescription Order includes more than one Drug, supply, or component/item, a separate cost share will apply to each.

Where You Can Get Prescription Drugs

In-Network Pharmacy

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

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

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

If we determine that a Pharmacy is dispensing excess or unnecessary Prescription Drug(s), dispensing Prescription Drug(s) not indicated by your records, or dispensing Prescription Drug(s) that are an unsafe practice or potentially harmful to you, we, on behalf of the employer, may limit the Prescription Drug(s) that the Pharmacy can dispense under the Plan. If you are impacted by these limitations, you will be notified of the Pharmacies with Prescription Drug limitations. If you continue to obtain Prescription Drug(s) specified in the notice from a Pharmacy no longer authorized to dispense that Prescription Drug to our Members, those Prescription Drug(s) will not be eligible for reimbursement under this Plan. Otherwise, Your benefits will not change. You can continue to obtain other Medically Necessary Prescription Drug(s) from the Pharmacy identified in the notice. In addition, you can continue to get the Medically Necessary Prescription Drug(s) listed in the notice when you obtain them from another authorized In-Network Pharmacy.

Maintenance Pharmacy

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

Specialty Pharmacy

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

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

Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Cost-Shares (Copayments / Coinsurance) you pay for a 30-day supply at a Retail Pharmacy. If you do not use the Specialty Pharmacy, benefits will be covered at the Out-of-Network level.

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

Home Delivery Pharmacy (Mail Order Pharmacy)

The PBM also has a Home Delivery Pharmacy that lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can have your Doctor send Prescriptions electronically, via fax or phone call, or you can submit written Prescriptions from your Doctor to the Home Delivery Pharmacy.

A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

Out-of-Network Pharmacy

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

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

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

What You Pay for Prescription Drugs

Tiers

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

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.

- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.

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

Please see the “Schedule of Benefits” details on your cost-shares.

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

Prescription Drug List

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

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

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

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

Exception Request for a Drug not on the Prescription Drug List:

If you or your Doctor believes you need a certain Prescription Drug not on the Prescription Drug List, please have your Doctor or pharmacist get in touch with us. The Plan will cover the other Prescription Drug only if we, on behalf of the Employer, agree that it is Medically Necessary and appropriate over the Drugs on the List. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Day supply limits for most Prescription Drugs are listed in the “Schedule of Benefits”. However, Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown in the “Schedule of Benefits” due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.

In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases you may be able to get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. We will work with the Pharmacy to decide when this should happen.

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

Therapeutic Equivalents

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

Split Fill Dispensing Program

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

Drug Cost-Share Assistance Programs

If you qualify for certain non-needs based drug cost share assistance programs offered by drug manufacturers (either directly or indirectly through third parties) to reduce the Deductible, Copayment, or Coinsurance you pay for certain Specialty Drugs, the reduced amount you pay may be the amount we apply to your Deductible and/or Out-of-Pocket Limit when the Prescription Drug is provided by an In-Network Provider. In addition, we may also enroll you in a program, the Cost Relief Program, that allows you to further reduce your costs, and may eliminate your out-of-pocket costs altogether. We will work with manufacturers to get the maximum cost share assistance you are eligible for, and will manage enrollment and renewals on your behalf.

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

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

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

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

Opting Out

If you do not wish to participate in this program, you can opt out, and you will be responsible for a portion of the cost of the Specialty Drug. Your cost will depend on the Specialty Drug prescribed and the level of cost share assistance that would have been available to you under the Cost Relief Program, but will not be more than 50% of the Maximum Allowed Amount.

Because certain Specialty Drugs are not classified as “essential health benefits” under the Plan in accordance with the Affordable Care Act, Member cost share payments for these Specialty Drugs, do not count towards the Plan’s Deductible or Out-of-Pocket Limit. If you have already met your Deductible or Out-of-Pocket Limit with other claims, you will still be required to pay a portion of the cost for these Specialty Drugs. A list of Specialty Drugs that are not considered to be “essential health benefits” is available. An exception process is available for determining whether a Specialty Drug that is not an essential health benefit is medically necessary for a particular individual.

Special Programs

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

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.

What's Not Covered Under Your Medical Services

1. **Administrative Charges**
    - Charges to complete claim forms,
    - Charges to get medical records or reports,
    - 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.
2. **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 Anthem.
3. **Alternative / Complementary Medicine** Services or supplies given by a provider for alternative or complementary medicine. This includes, but is not limited to:
    - Acupuncture, except as provided for pain management,
    - Acupressure,
    - Holistic medicine,
    - Homeopathy or Homeopathic medicine,
    - Hypnosis,
    - Aroma therapy,
    - Massage and massage therapy, except for massage therapy services that are part of a physical therapy treatment plan and covered under the "Therapy Services" section of this Booklet,
    - Reiki therapy,
    - Herbal, vitamin or dietary products or therapies,
    - Naturopathic services, unless a Covered Service under this Plan,
    - Thermography,
    - Orthomolecular therapy,
    - Contact reflex analysis,
    - Bioenergial synchronization technique (BEST),
    - Iridology-study of the iris,
    - Auditory integration therapy (AIT),
    - Colonic irrigation,
    - Magnetic innervation therapy,
    - Electromagnetic therapy,
    - Neurofeedback / Biofeedback.

4. **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) for all indications except as described under Autism Services in the "What's Covered" section unless otherwise required by law.
5. **Autopsies** Autopsies and post-mortem testing.
6. **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.
7. **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), physical therapist technicians, and athletic trainers.
8. **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
9. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims as outlined in the "Surprise Billing Claims (Surprise Bill)" section under the "Claims Payment" section.
10. **Chats or Texts** Chats and texting are not a Covered Service unless appropriately provided via a secure and compliant application, according to applicable legal requirements.
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 Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
15. **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

    This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy.
16. **Court Ordered Testing** Court ordered testing or care unless Medically Necessary.
17. **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if: during the time of the crime or attempted crime you had an elevated blood alcohol content or were under the influence of an intoxicating liquor or any drug or both; or your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.

18. **Custodial Care** Custodial Care, unless otherwise required by Federal or State law, 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** 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, unless the chewing or biting results from a medical or mental condition.
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“ benefit 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 may be excluded if they 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 Walk-In Center, Urgent Care Facility (Urgent Care Center) or your Primary Care Physician / Provider.
29. **Experimental or Investigational Services** Services (treatments, procedures, facilities, equipment, drugs, devices) or supplies that we find are Experimental / Investigational. This also applies to services related to or associated with Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply. The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.
30. **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
31. **Eye 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.
32. **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.
33. **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.

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:
    - Cleaning and soaking the feet.
    - Applying skin creams to care for skin tone.
    - Other services that are given when there is not an illness, injury or symptom involving the foot.
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. **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.
38. **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.
39. **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.
40. **Home Health Care Services**
    - 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.
    - Food, housing, homemaker services and home delivered meals.
41. **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.
42. **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
43. **Infertility Services After Naturally Occurring Menopause** Infertility services for a person with natural menopause is not covered under this Plan. Menopause is considered a natural process.
44. **Infertility Treatment Infertility** procedures not specified in this Booklet.
45. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
46. **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur, unless required under state or federal law. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "What's Covered" section.
47. **Medical Equipment, Devices, and Supplies**
    - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
    - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
    - Non-Medically Necessary enhancements to standard equipment and devices.

- Supplies, equipment and appliances, including hearing aids and wigs, 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, including items you purchase with features that exceed what is Medically Necessary, will be limited to the Maximum Allowed Amount for the standard item, and the additional costs will be your responsibility.
- 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.
- Diabetic equipment and supplies, including Continuous glucose monitoring systems. These are covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit. This does not include Insulin pumps and Insulin pump supplies.

48. **Medicare** For which benefits are payable under Medicare Parts A and/or B, except as required by law, as described in the section titled "Medicare" in “General Provisions.”
49. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
50. **Non-approved Drugs** Drugs not approved by the FDA.
51. **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
52. **Non-Medically Necessary Services** Services the Plan concludes are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
53. **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.
54. **Off label use** Off label use, unless we must cover it by law or if we approve it.
55. **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.
56. **Personal Care, Convenience, and Mobile/Wearable Devices**
    - Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
    - 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),
    - Home workout or therapy equipment, including treadmills and home gyms,
    - Pools, whirlpools, spas, or hydrotherapy equipment.
    - Hypoallergenic pillows, mattresses, or waterbeds,
    - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
    - Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
57. **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.
58. **Prosthetics** Prosthetics for sports or cosmetic purposes.

59. **Reduction in benefits and Penalties** Any reduction in benefits, including Penalties, are not considered a Cost-Share and do not apply to your Out-of-Pocket Limit. Any reduction in benefits or Penalties imposed by another Plan are not reimbursable as a Covered Service under this Plan.
60. **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:
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
    - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included.
    - Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or Mental Health orSubstance Use Disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps.
61. **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.
62. **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely.
63. **Sexual Dysfunction** Services or supplies for male or female sexual problems.
64. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
65. **Sterilization** Services to reverse an elective sterilization.
66. **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).
67. **Temporomandibular Joint Treatment (TMJ)** Surgical and Non-surgical Services or supplies for the treatment of temporomandibular and craniomandibular disorders. This includes surgery, medical care, diagnostic services, physical therapy, fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).
68. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
69. **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
70. **Vision Services** Vision services not described as Covered Services in this Booklet.
71. **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.
72. **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.

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

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

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by the Plan or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
4. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law, such as for pain management. "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.
5. **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
6. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
7. **Delivery Charges** Charges for delivery of Prescription Drugs.
8. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
9. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com.
10. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by Anthem.
13. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the "Preventive Care" benefit of the "What's Covered" section.
14. **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.
15. **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.

16. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Gene Therapy Services" benefit. Please see that section for details.
17. **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.
18. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
19. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit may be covered under the "Durable Medical Equipment (DME), Medical Devices, and Supplies" benefit. Please see that section for details.
20. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
21. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
22. **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
23. New Prescription Drugs, Indications, and/or Dosage Forms New Prescription Drugs, new indications and/or new dosage forms will not be covered until the date they are reviewed and placed on a tier by our Pharmacy and Therapeutics (P&T) Process. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to the "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
24. **Non-approved Drugs** Drugs not approved by the FDA.
25. **Non-Medically Necessary Services** Services the Plan concludes are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
26. **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.
27. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
28. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
29. **Over-the-Counter Items** Drugs, devices and products, or Prescription Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Drugs when any version or strength becomes available over the counter, unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

This Exclusion does not apply to over-the-counter products that must be covered as a “Preventive Care” benefit under federal law with a Prescription. Prescription or to FDA-approved over- the-counter hearing aids when Members have been certified as deaf or hearing impaired by a Physician or licensed audiologist.

30. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
31. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
32. **Weight Loss Drugs** Any Drug mainly used for weight loss.

Claims Payment

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you. 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 (MAA)

General

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

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

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

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Except for Surprise Billing Claims, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

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.

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

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

For Covered Services You receive from an Out-of-Network Provider for services approved as an Authorized Service, using one of the following as determined by us, on behalf of the Group:

1. An amount based on our Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is adjusted or unadjusted for geographic locality, no less than annually; or

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

4. An amount negotiated by 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.

For Emergency services You receive from an Out-of-Network Provider, the Maximum Allowed Amount will be the greatest of the following amounts:

1. The amount the insured's health care plan would pay for such services if rendered by an In-Network health care provider. This includes urgent crisis center services
2. The usual, customary and reasonable rate for such services, ("Usual, customary and reasonable rate" means the eightieth percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported by FAIR Health, Inc) or
3. The amount Medicare would reimburse for such services.

Providers who are not contracted for this Plan, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services

from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

For Covered Services rendered outside Anthem's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount unless your claim involves a Surprise Billing Claim. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out-of-pocket costs to you. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com.

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

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

Member Cost-Share

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

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

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.

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

We and/or our designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to

certain Prescription Drug purchases under this Benefit Booklet and which positively impact the cost effectiveness of Covered Services. These amounts are retained by us. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

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

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

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

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

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. If we authorize an In-Network cost-share amount to apply to a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claims involves a Surprise Billing Claim. Please contact Member Services for additional Authorized Services information or to request authorization.

Surprise Billing Claims (Surprise Bill)

Federal law protections against balance billing apply to care received in emergency settings and in in-network facilities from out-of-network providers. The law requires private health plans to cover surprise medical bills for emergency services, including air ambulance services (but not ground ambulance services), as well as Out-of-Network provider bills for services rendered at In-Network hospitals and facilities.

Patients are responsible for cost-sharing no greater than what they pay for In-Network care, and their cost-sharing applies to their In-Network Deductible and Out-of-Pocket limit. Your cost shares for Surprise Billing Claims will be calculated based on the Recognized Amount. Providers and facilities are barred from sending patients a bill for amounts other than cost sharing that exceed the amount paid by the health plan or insurer.

A Surprise bill does not include a bill for Covered Services received by a Member when an In-Network Provider was available to render such services and the Member knowingly elected to obtain such services from another Provider who was Out-of-Network.

In certain situations, an Out-of-Network Provider must provide you with notice of their status as Out-of-Network. Should you agree in advance to accept services from an Out-of-Network Provider, you will be responsible for the Out-of-Network Cost-shares and any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This is also referred to as the notice and consent requirement.

If you feel you have had a service that is covered under the Surprise Billing Claims protections, you have the right to appeal those claims. Please see the "Grievance Review Process" section for more information.

Federal/State Taxes/Surcharges/Fees

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

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Notice of Claim & Proof of Loss

As Claims Administrator, we must receive written notice of your claim after you receive Covered Services in order for benefits to be paid.

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.

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

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

  Out-of-Network claims must be submitted within 90-days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 90-day period.

The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

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

Upon receiving a claim, we will process it within 60-days for paper claims and 20-days for electronic claims unless another timeframe is required under state or federal law. If the claim does not include enough information, we will send a request to you or your Provider for addition information within 30-days for paper claims and 10-days for electronic claims. Once we receive the required information, the claim will be processed according to the terms of your Plan within 30-days for paper claims and 10- days for electronic claims.

We have, as the Claims Administrator, the right to enforce the Group's rights under this provision.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

Payment of Benefits

You authorize us, on behalf of the Group, to make payments directly to Providers for Covered Services. In no event, however, shall payments made directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. We reserve the right, on behalf of the Group, to make payments directly to you as opposed to any Provider for Covered Service, at the Plan's discretion, except for claims for Emergency Care or Surprise Billing Claims for air ambulance services or non-Emergency services performed by Out-of-Network Providers at certain In-Network Facilities, which will be paid directly to Providers and Facilities. Notwithstanding any limitations or restrictions on assignment of benefits contained in this certificate, Anthem will not deny or refuse to honor any assignment of benefits for Covered Services made to a dentist or oral surgeon subject to compliance with the requirements of applicable Connecticut insurance law governing assignment of benefits.

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 (QMCSO)" as having a right to enrollment under the Group's Plan), or that person's custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or You) will discharge 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 (QMCSO)" 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.

Explanation of Benefits (EOB)

After receiving medical care, you should receive an Explanation of Benefits (EOB) – a summary of coverage received. The EOB is not a bill, but a statement from Us to help You understand the coverage You received.

The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges covered by your medical plan.
- The amount you are responsible for (if any).
- General information about your rights to an appeal and your rights regarding any action after the appeals process.

You have a choice about how you receive your EOB and where it goes. You can let us know:

- Not to send an EOB,
- To send an EOB by providing a mailing address.
- To send an EOB electronically. We will send you a notification by e-mail or other electronic means selected by you when the EOB is available to review.

If You want to request an alternate method of delivery or suppression of an EOB, these requests must be submitted in writing to be considered.

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 both kinds of Providers are paid.

Inter-Plan Arrangements Eligibility – Claim Types

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

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

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.

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 Anthem 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.

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, on behalf of the Group, include any such surcharge, tax or other fee as part of the claim charge passed on to you.

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, on behalf of the Group, 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 that was made 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, on behalf of the Group, 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 made for the Covered Services as set forth in this paragraph.

Blue Cross Blue Shield Global Core ®

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

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

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

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

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

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

- Doctors services;

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

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

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

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

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

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

All benefits provided under this Plan are subject to the Coordination of Benefits provision as described in this Section.

Understanding Coordination of Benefits

Applicability

The Coordination of Benefits (COB) provision applies to this Plan when you have health coverage under more than one Plan.

If you are covered by this Plan and another Plan, the “Order of Benefit Determination Rules” in this section shall determine which Plan is the primary Plan.

The benefits of this Plan:

- Shall not be reduced when under the “Order of Benefit Determination Rules” this Plan is the primary Plan; but
- May be reduced or the reasonable cash value of any Covered Service provided under this Plan may be recovered from the primary Plan when under the “Order of Benefit Determination Rules” another Plan is the primary Plan. The above reduction is described in the “Effect Of This Plan On The Benefits Policy” Subsection;
- Penalties imposed on you by the primary carrier are not subject to COB;
- You must submit the explanation of benefits from the primary Plan to Anthem within two years of the date of service in order to be eligible for payment under this Coordination of Benefits Section.

Allowable Expense

A Medically Necessary item of expense for health care that is covered at least in part by one or more Plans covering the Member for whom the claim is made, including applicable Cost-Shares, is an Allowable Expense. When this Plan provides Covered Services, the reasonable cash value of each Covered Service is the Allowable Expense and is a benefit paid.

Allowable Expense does not include coverage for:

- Services not provided for under this Plan.
- Any reduction in benefits or Penalties imposed by another Plan because you did not comply with the provisions of that Plan, are not reimbursable as a Covered Service under this Plan.
- The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient’s stay in a private Hospital room is Medically Necessary.
- 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.

Some services may not coordinate as an Allowable Expense, this may include but is not limited to: Dental care, Vision care, or hearing aid programs.

Claim Determination Period

The Claim Determination Period is your Benefit Period. However, it does not include any part of a Benefit Period during which a person has no coverage under this Plan, or any part of a Benefit Period before the date this COB provision or a similar provision takes effect.

Plan

For the purpose of this Section, a Plan means any of the following which provides benefits or services for, or because of, medical care or treatment:

- Group health insurance, group-type coverage, whether fully insured or self-insured, or any other contract or arrangement where a health benefit is provided. This includes prepayment, staff or group practice association health maintenance organization coverage.

- Coverage under a governmental Plan or required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, or the United States Social Security Act as amended from time to time). It also does not include any Plan when, by law, its benefits are in excess of those of any private insurance program or other non-governmental program.

- Medical benefits coverage of no-fault and traditional automobile fault contracts, as provided in this Section.

Each contract or other arrangement for coverage as described above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

Primary Plan

A Primary Plan is a Plan whose benefits for a person’s health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a Primary Plan if either provision below is true:

- The Plan either has no Order of Benefit Determination rules or it has rules which differ from those stated in this Section; or
- All Plans which cover the person use the Order of Benefit Determination rules as stated in this Section and under those rules the Plan determines its benefits first. There may be more than one Primary Plan (for example: two Plans which have no Order of Benefit Determination rules).

When this Plan is the Primary Plan, Covered Services are provided or covered without considering the other Plan’s benefits.

Secondary Plan

A Secondary Plan is a Plan which is not a Primary Plan. If you are covered by more than one Secondary Plan, the Order of Benefit Determination rules of this Section decide the order in which your benefits are determined in relation to each other. The benefits of the Secondary Plan may take into consideration the

benefits of the Primary Plan or Plans and the benefits of any other Plan which, under the rules of this Section, has its benefits determined before those of the Secondary Plan.

When this Plan is the Secondary Plan, benefits for Covered Services under this Plan may be reduced and Anthem may recover from the Primary Plan, the Provider, or you, the reasonable cash value of the Covered Services provided by this Plan.

Order of Benefit Determination Rules

General Rule

When you receive Covered Services by or through this Plan or is otherwise entitled to claim benefits under this Plan and has followed all Our guidelines and procedures, including Precertification requirements as specified in this Booklet, and the Covered Services are a basis for a claim under another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

- The other Plan has rules coordinating its benefits with those described in the Booklet; and
- Both the other Plan's rules and this Plan's coordination rules, as described below, require that this Plan's benefits be determined before those of the other Plan.

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.

Coordination Rules

We determine the order of benefits, on behalf of the Group, using the following rules:

Other than a Dependent

The benefits of the Plan which covers the person as a Subscriber (that is, other than as a Dependent) are primary to those of the Plan which covers the person as a Dependent.

Dependent Child/Parents Not Separated or Divorced

When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" the Plan of the parent whose birthday falls earlier in a year is primary to the Plan of the parent whose birthday falls later in that year, but if both parents have the same birthday, the Plan which covered a parent longer is primary. Only the month and day of the birthday are considered.

Dependent Child/Separated or Divorced Parents

When a claim is made for a Dependent child:

- When the parents are separated or divorced and the parent with legal custody of the child has not remarried, the benefits of a Plan which covers the child as a Dependent of the parent with legal custody of the child shall be determined before the benefits of a Plan which covers the child as a Dependent of the parent without legal custody.

- When the parents are divorced and the parent with legal custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent.

The benefit of a Plan which covers that child as a Dependent of the step-parent shall be determined before the benefits of a Plan which covers that child as a Dependent of the parent without legal custody.

If the specific terms of a court order state that one of the parents is financially responsible for the health care expenses of the child, then the Plan which covers the child as a Dependent of the financially responsible parent shall be determined before the benefits of any other Plan which covers the child as a Dependent child. The provisions of this Subsection do not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.

Active/Inactive Employee

A Plan which covers you as an employee who is neither laid off nor retired (or a Plan that covers you as a Dependent) is primary to a Plan which covers you as a laid-off or retired employee (or a Plan that covers you as a Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the Plan which covered you longer is primary to the Plan which covered you for a shorter time.

Medicare

If you are eligible for Medicare and still covered under this Plan, We will provide the benefits of this Plan, except as required by law. However, these benefits will be reduced to an amount which, when added to the benefits received pursuant to Medicare, may equal, but not exceed the actual charges for services covered in whole or in part by either this Plan or Parts A, B and D of Medicare.

(Note: Certain services may not require Precertification when it is determined that We are the Secondary Plan. Contact Member Services before any services are rendered to determine if such services require Precertification. In the event that a later determination finds that We are the Primary Plan, any services that were obtained without Precertification while We were administering benefits as a Secondary Plan will not require Precertification as would be required under a Primary Plan.)

Effect Of This Plan On The Benefits

1. This Subsection applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Plan may be reduced under this Subsection. Such other Plan or Plans are referred to as “the other Plans”.

2. Reduction in this Plan’s benefits. When this Plan is the Secondary Plan, Anthem will provide benefits under this Plan so that the sum of the reasonable cash value of any Covered Service provided by this Plan and the benefits payable under the other Plans shall not total more than the Allowable Expense. Benefits will be provided by the Secondary Plan at the lesser of: the amount that would have been paid had it been the Primary Plan or the balance of the bill. We will never pay, on behalf of the Group, more than it would have paid as the Primary Plan.

If another Plan provides that its benefits are “excess” or “always secondary” and if this Plan is determined to be secondary under this Plan’s COB provisions, the amount of benefits payable under this Plan shall be determined on the basis of this Plan being secondary. If the non-complying Plan does not provide the information needed by this Plan to determine its benefits within a reasonable time after it is requested to do so, this Plan shall assume that the benefits of the non-complying Plan are identical to its own, and shall pay its benefits accordingly. However, this Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the non-complying Plan.

Right To Receive And Release Needed Information

Certain information is needed to apply these COB rules. We have the right to decide which information it needs. By enrolling in this Plan you consent to the release of information necessary to apply the COB rules. Anyone claiming benefits under this Plan must furnish information to Us which We determine is necessary for the coordination of benefits.

Facility Of Payment

A payment made or a service provided under another Plan may include an amount which should have been paid or provided under this Plan. If it does, we may pay, on behalf of the Group, that amount to the organization which made that payment. Such amount shall then be considered as though it were a benefit paid under this Plan.

Right Of Recovery

If the amount of the payments made by Us, on behalf of the Group, is more than it should have paid under this COB provision, or if it has provided services which should have been paid by the Primary Plan, We may recover the excess or the reasonable cash value of the Covered Services, as applicable, from one or more of the persons it has paid or for whom it has paid, insurance companies, or other organizations.

The right of the Plan to recover from you shall be limited to the Allowable Expense that you have received from another Plan. Acceptance of Covered Services will constitute consent by you to Our right of recovery. You agree to take all further action to execute and deliver such documents that may be required and do whatever else is necessary to secure the Plan’s rights to recover excess payments. Your failure to comply may result in a withdrawal of benefits already provided or a denial of benefits requested.

We have, as the Claims Administrator, the right to enforce the Group’s rights under this provision.

Grievance Review Process

You may have questions about your Health benefit plan. Since questions can often be handled informally, these questions may be addressed by contacting Member Services, please call the number on the back of your Identification Card. In addition, information about the following the Grievance Review Procedures, also known as the Appeal Process, may be obtained by contacting Member Services.

Member Services

You may have questions about your Health benefit plan. You usually will be able to answer your benefits questions by referring to this Booklet. However, if you need help you can call or write Member Services.

Questions?	Member Services is available to explain policies and procedures; and answer your questions about membership, benefits, or claims.
Connect with Us:	Our goal is to make it easy for you to find answers to your questions, and to connect with us. You can: • visit or chat with us live in the app, or • log on and contact us on our website, www.anthem.com, or • contact Member Services by calling the number on the back of your ID card.
Home Office Address:	You may write or visit our home office during normal business hours at Anthem Blue Cross Blue Shield, Member Services, 108 Leigus Road, Wallingford, CT 06492
Normal Business hours:	Monday through Friday – 8:00 a.m. to 5:00 p.m.
What you will need when you contact us:	Please have your Identification Card with your ID number on hand. If your question involves a claim; we will need to know the date(s) of service, the name of the Provider, and the charges involved.

Rights Available to Members

You may ask for and get copies of all documents including the actual benefit provision, guideline, protocol or other similar criterion on which an adverse coverage decision was based. If you prefer, any other person you choose may ask for this information. We will send this information within five business days after receiving your request. We will send this information within one calendar day after receiving your request about a final adverse coverage decision for:

- An admission, availability of care, continued stay, or health care service for which you received emergency services but haven't been discharged from a facility; or
- A denial of coverage based on a decision that the recommended or requested health care service or treatment is experimental or investigational and your treating provider certifies in writing that this care service or treatment would be significantly less effective if not promptly initiated.

We will send the information by fax, electronic means or any other fast method.

If you don't agree with our coverage decision, you have the right to ask for a grievance. The review of your grievance may change our previous coverage decision.

Other Helpful Resources

Whether or not you use the grievance rights available to you, you may contact the Consumer Affairs Division of the Connecticut Insurance Department or the Connecticut Office of the Health Care Advocate at any time. You may also benefit from free assistance with filing a grievance.

Consumer Affairs Division of the Connecticut Insurance Department

Address:	P.O. Box 816 Hartford, CT 06142-0816
Phone:	860-297-3900 (local) 800-203-3447 (toll-free)
Email:	cid.ca@ct.gov

Connecticut Office of the Health Care Advocate

Address:	P.O. Box 1543 Hartford, CT 06144
Phone:	866-466-4446 (toll-free)
Email:	Healthcare.advocate@ct.gov

If You Have a Complaint or An 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 your plan or a service you have received. In those cases, please call Member Services at the phone number on your ID card. We will try to resolve your complaint informally. If you are not satisfied with the resolution of your complaint, you have the right to file a grievance (also known as an appeal). You must file a grievance within 180 calendar days from the date you get a decision from us that you do not agree with. The review of your grievance may change our previous coverage decision.

Include the following details with your grievance if you have them:

- The member's name and ID number;
- The name of the provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which you don't agree;
- The specific reason(s) why you don't agree with the decision; and
- Any written comments, documents or other relevant information to support the request.

At any time, you can name someone to act for you. You must do this in writing.

To file a grievance, you, your doctor, or any person you choose (your authorized representative) can request a grievance in writing or by calling Member Services at the phone number on your ID card. Your grievance should be sent to one of the following addresses:

For Medical and Prescription Drug or Pharmacy Issues:
Anthem Blue Cross and Blue Shield
Grievances and Appeals
P.O. Box 1038
North Haven, CT 06473-4201

For Mental Health and Substance Use Disorder Issues:
Anthem Blue Cross and Blue Shield
Grievances and Appeals
P.O. Box 2100
North Haven, CT 06473-4201

How are Grievances Handled?

If your grievance is based on medical necessity, the appropriate clinical peer will review the grievance and has the ability to change the outcome of our initial determination. A clinical peer is a doctor or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. For a substance use or mental health disorder, the clinical peer will have additional qualifications. All relevant information given to us by you or on your behalf will be reviewed regardless of whether it was considered at the time the initial decision was made. If your grievance involves a substance use or mental health disorder, we will use the required criteria to review your request.

If your grievance is not based on medical necessity, we will send it for appropriate administrative review.

We may reach out to any providers who may have additional information to support your grievance. The reviewers will not have been involved in the initial decision. They also will not be a subordinate (in a lower position) of the person who made the initial decision.

Before issuing a decision on a grievance of an adverse coverage decision based on medical necessity, we will give you, free of charge, any new or additional evidence relied upon or scientific or clinical rationale. We will give you this information in advance of the grievance resolution date. This will allow you a reasonable amount of time to respond before that date.

Standard (Non-urgent) Grievance

You may ask for a standard grievance (a grievance that is not urgent) for a coverage decision you don’t agree with. You can also ask for a standard grievance for a rescission (ending or canceling) of coverage. Your request must be in writing. In your request, please let us know that you are asking for a grievance. Include any additional information you have to support your request.

We will respond to a grievance for a medical necessity decision within 30 calendar days from the date we get the request. If the decision is not based on medical necessity, we will respond within 30 business days from the date we get the request. Our response will be in writing.

Urgent (Expedited) Grievances

An urgent grievance is available if you have not had or are currently receiving services and the timeframe of a standard grievance review could:

- Seriously jeopardize (harm) your life or health;
- Jeopardize your ability to regain maximum function; or
- In the opinion of a health care professional with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the health care service or treatment being requested.

We will let you know our decision within 48 hours of receiving a request, or 72 hours from receipt of request if any portion of 48 hours period falls on a weekend for an urgent grievance described in this section. We will let you know our decision by phone, fax, or any other available means.

For urgent grievances related to Mental Health and Substance Use Disorder disorders please see the next section.

While you may file an urgent grievance in writing, we encourage you to call Member Services with this type of request. This will help us handle the review fast.

Mental Health Disorder and Substance Use Disorder

An urgent grievance is also available for:

- Substance use disorder or co-occurring mental health disorder; or
- Inpatient services, partial hospitalization, residential treatment, or intensive outpatient services needed to keep you from requiring an inpatient setting in connection with a mental health disorder.

We will let you know our decision within 24 hours of receiving a request for an urgent grievance described in this section. We will let you know our decision by phone, fax, or any other available means.

While you may file an urgent grievance in writing, we encourage you to call Member Services with this type of request. This will help us handle the review fast.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law.

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

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

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited

External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

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

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

Anthem Blue Cross and Blue Shield
ATTN: Grievance & Appeals/External Appeals
P.O. Box 1038
North Haven, CT 06473

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care 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.

Prescription Drug List Exceptions

Please refer to the "Prescription Drug List" section in "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for the process to submit an exception request for Drugs not on the Prescription Drug List.

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

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from the Department of Health and Human Services and Department of Labor.

ERISA Rights

If your health benefit plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and you have exhausted all mandatory grievance rights, you have the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA.

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, or retiree of the Group, and
- Be entitled to participate in the benefit Plan arranged by the Group;
- Have satisfied any probationary or waiting period established by the Group and (for non-retirees) and perform the duties of your principal occupation for the Group.

Dependents

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

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

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Group has determined are covered under a Qualified Medical Child Support Order (QMCSO) 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.

You must notify us if the Dependent's status changes and if they are no longer eligible for continued coverage.

All enrolled eligible children will continue to be covered until the Plan renewal date once they reach 26 years of age. Coverage may be continued past the age limit for Dependent children already enrolled in the Plan in the following circumstances:

- Dependents who cannot work to support themselves due to a mental or physical impairment and for whom the Subscriber and/or Spouse is primarily responsible for their support and maintenance.
- The Dependent's incapacity must start before the end of the period they would become ineligible for coverage.
- We must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible.

You and your Dependent child's treating Physician / Provider must complete the "Certification for a Mentally or Physically Impaired Dependent Child Over Maximum Age" or other certification form provided by us. This form requires documentation that the Dependent is financially reliant on you or your spouse's support. Typically, this is provided in the form of federal tax returns showing the child as a Dependent or other documentation acceptable to us. You must then give proof as often as we require. This will not be

more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to us.

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

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

When You Can Enroll

Initial Enrollment

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

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

Open Enrollment

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

Special Enrollment Periods

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

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 Group's Prior Plan

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

If at the time of the Effective Date of coverage you or your covered dependents become eligible for coverage under this Plan while inpatient at a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or Residential Treatment Facility, the coverage under this Plan will be effective. To the extent that the costs of hospitalization, inpatient stay or any medical care relating to that hospitalization or inpatient stay are the responsibility of a previous carrier, the payment of these claims will be coordinated with the previous carrier in accordance with State law. You should notify us when an inpatient stay under these circumstances occurs.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth a child, you should submit an application / change form to the Group within 61 days to add the newborn to your Plan.

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

Adopted Children

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

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

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded legal custody or guardianship for a child, an application must be submitted within 60 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 (QMCSO)

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 "Who is Eligible for Coverage" under "Dependents".

Updating Coverage and/or Removing Dependents

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

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

Failure to notify us or the Group of individuals no longer eligible for services will not obligate us 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.

Statements and Forms

All Members must complete and submit applications, or other forms or statements that we or the Group may reasonably be requested.

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 Contract or Administrative Services Agreement between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.

- If you choose to terminate your coverage.

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

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

- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30-calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or Fees paid for such services.

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

- 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 Group.

Removal of Members

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

Continuation of Coverage Under Federal Law (COBRA)

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

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

Qualifying events for Continuation Coverage under Federal Law (COBRA)

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

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

Qualifying Event	Length of Availability of Coverage
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 Group Offers Retirement Coverage

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

Second qualifying event

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

Notification Requirements

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

You Must Give Notice of Some Qualifying Events

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

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Fees appropriate for the type of benefit coverage you choose to continue. If the Fees rate changes for active associates, your monthly Fees will also change. The Fees 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 Fees 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 Fees 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 Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

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

If You Have Questions

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

Continuation of Coverage 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:

- The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
    - The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
    - 14 days after completing military service for leaves of 31 to 180 days,
    - 90 days after completing military service for leaves of more than 180 days; or
- 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 Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

Right of Recovery for Municipal Groups

To the extent permissible by law, Anthem BCBS shall have a right of recovery for the cost of Covered Services against Members enrolled in Plans sponsored by a municipality who receive benefits for Covered Services as a result of an accident or other act by a third party that causes injury to a Member where the Member later recovers damages from the third party (or its insurer) for injuries and other liabilities caused by the third party.

Acceptance of Covered Services will constitute consent by the Member to Anthem BCBS's right of recovery. The Member agrees to take all further action to execute and deliver such additional instruments and to take such other action as Anthem BCBS shall require to implement this provision. Anthem BCBS will have the right to bring suit against such third party in the name of the Member and in its own name as subrogee. The Member shall do nothing to prejudice the rights given to Anthem BCBS by this provision without its consent.

If a Member received payment from a third party by suit or settlement for the cost of Covered Services, such Member is obligated to reimburse Anthem BCBS less Anthem BCBS's pro rata share of the reasonable attorney's fees and cost the Member sustained in obtaining the recovery.

In the case of any city, town, borough or municipality entitled to the rights granted under C.G.S. Section 7-464 (c), as amended or superseded, this Booklet shall include the lien rights granted to the self-insured city, town, borough, or municipality under that Section of the law and shall be subject to the provisions contained in that Section.

The employee, covered dependent or family member shall reimburse the self-insured town, city, municipality or borough from any tortfeasor recovery for medical, hospital and prescription expenses paid due to the negligence of a third party as limited by the provisions of Section 7-464 (c), as amended or superseded by law.

For purposes of this subsection the definition of "tortfeasor recovery" means moneys paid by or on behalf of the person or entity whose negligence or recklessness caused the injuries for which medical, hospital and prescription expenses were incurred.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

General Provisions

Assignment

The Group 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.

Automobile Insurance

To the extent allowed by law, we will not provide benefits under this plan for covered services paid, payable or required to be provided as basic benefits under any no-fault or other automobile insurance policy.

We have, on behalf of the Group, the right to:

- Charge the insurer, as allowed under such law, for the value of Covered Services that you are entitled;
- Charge you for the value of Covered Services for which you have received payment from any and all sources, including but not limited to first party payment.
- Reduce the amount we owe to you by the amount that you have received payment from any and all sources, including but not limited to first party payment.
- Apply your benefits under this Plan to the coordination of benefits rules described in the “Coordination of Benefits When Members Are Insured Under More Than One Plan” section, for Covered Services you receive under an automobile insurance policy which provides benefits without regard to fault.
- Consider you, your own insurer if you fail to secure no-fault insurance as required by law. Your benefits will be reduced for Covered Services by the amount that would have been covered (e.g., for basic benefits or other benefits provided for injury) if such a no-fault policy had been obtained.
- Require you to follow the guidelines and requirements of this Plan for Covered Services. If your benefits under a no-fault or other automobile insurance policy run out, then benefits will continue to be provided for Covered Services under this Plan provided they would otherwise be covered under this Plan. Please see the “Getting Approval for Benefits” section for more information.

We have, as the Claims Administrator, the right to enforce the Group’s rights under this provision.

Care Coordination

We pay, on behalf of the Group, In-Network Providers in various ways to provide Covered Services to you. For example, sometimes we may pay In-Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, we may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient

manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to us under these programs.

Circumstances Beyond the Control of the Plan

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

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

By your application, you have agreed to allow your Providers to give us, as Claims Administrator, the needed information about the care they provide to you, to the extent permitted by law.

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

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

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with the law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and the Claims Administrator, Anthem Blue Cross Blue Shield dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Connecticut. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an

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

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.

Entire Agreement

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

Form or Content of Booklet

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

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, under any other governmental program. This does not apply if any particular laws require us to be the primary payer. If we have, on behalf of the Group, 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 the Plan to be the primary payer, the benefits under this Plan do not duplicate any benefit for which Members are entitled to or enrolled in under Medicare. 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.

Payments will not be reduced based on if you are eligible for Medicare by reason of age, disability, or end-stage renal disease, unless you enroll in Medicare. If you enroll in Medicare, any such reduction shall be only to the extent such coverage is provided by Medicare.

Member Rights and Responsibilities

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

It can be found on our website FAQs. To access, go to www.anthem.com and select Member Support. Under the Support column, select FAQs and your state, then the "Laws and Rights That Protect You" category. Then click on the "What are my rights as a member?" question. Members or Providers who do not have access to the website can request copies by contacting Anthem, or by calling the number on the back of the Member ID card.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, Administrative Services Agreement, or by mutual agreement between the Group and us without the permission or involvement of any Member. By electing medical and Hospital coverage under the Plan or accepting this Plan's benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Booklet.

Not Liable for Provider Acts or Omissions

Your Group 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 Group based on the actions of a Provider of health care, services, or supplies. The Group, Claims Administrator, and Network Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of

the Plan. The Plan will not be liable for any act or omission of any Provider or any agent or employee of a Provider. Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Payment Innovation Programs

We pay, on behalf of the Group, 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

On behalf of the Employer, we are able to adopt new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make administration of the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Administrative Services Agreement, we, on behalf of the Employer, have the authority, in our [sole] discretion, to institute from time to time, pilot or test programs for utilization management, care management, case management, clinical quality, disease management or wellness 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 Group, may offer health related 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 health

related items including but not limited to retail coupons, gift cards, merchandise, and discounts on fees or Member cost-shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue a program or an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. As the Claims Administrator of your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of Anthem's Notice, contact the Member Services number on the back of your Identification Card.

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 with 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 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, we will, on behalf of the Group, have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

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. Cross plan offsetting is a type of payment correction with a Provider. This occurs when we overpay a claim due to a billing error by a Provider (In-Network or Out-of-Network). The overpayment is then reimbursed to us, or offset, by adjusting another payment owed to the same Provider.

We have, as the Claims Administrator, the right to enforce the Group’s rights under this provision.

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

On behalf of the Group, we may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Voluntary Clinical Quality Programs

On behalf of the Group, we may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to 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.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

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

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back to us by you, or on your behalf, if we have made or if we make a payment for the services you received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

To the extent allowed by law no benefits shall be provided under this Plan for Covered Services paid, payable, or eligible for coverage under any: Workers' Compensation Law; employer's liability; or occupational disease law; denied under a managed Workers' Compensation program as Out-of-Network services; or which, by law, were rendered without expense to you.

We have, on behalf of the Group, the right to:

- Charge the entity obligated under such law for the value of Covered Services to which you are entitled.
- Charge you for the value of Covered Services from which you have received payment.
- Reduce the amount we owe to you by the amount that you have received payment.
- Place a lien on any amount we have paid for Covered Services rendered to you in the event that there is a disputed claim between the Group and the designated Workers' Compensation insurer as to whether or not you are entitled to receive Workers' Compensation benefits payments.
- Recover any such amount owed to us as described above in the event that the disputed and/or controverted claim is resolved by financial settlement to the full extent of such settlement.
- Require you to follow the guidelines and requirements of this Plan for Covered Services. If your benefits under Worker's Compensation, employer's liability or occupational disease law run out, then we will continue to provide benefits for Covered Services under this Plan provided they would otherwise be covered under this Plan. Please see the "Getting Approval for Benefits" section for more information.

We have, as the Claims Administrator, the right to enforce the Group's rights under this provision.

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.

Actively at Work

The term Actively At Work means the employee must work at the Employer Group's place of business or at such place(s) as normal business requires. The employee must perform all duties of the job as required of an employee and work the minimum number of hours required per week on a regularly scheduled basis. Eligible employees who do not satisfy the criteria, solely due to a health-related reason, are considered Actively At Work for purposes of initial eligibility under the Plan.

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 (Surgical Center)

A facility licensed as an Ambulatory Surgery Center as required by law that must satisfy our accreditation requirements and be approved by us.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim is a Surprise Billing Claim. Please see the "Claims Payment" section for more details.

Autism Behavioral Therapy Provider

Means Behavioral Therapy provided or under the supervision of a behavior analyst certified by the Behavior Analyst Certification Board; a licensed physician, or a licensed psychologist. "Supervision" means at least 1 hour of face-to-face supervision of the Autism Services Provider for each ten hours of Behavioral Therapy provided by the supervised certified assistant behavior analyst or behavior therapist.

Autism Spectrum Disorders

"Autism spectrum disorders" means the "Autism spectrum disorders" as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". The results of an autism spectrum diagnosis shall be valid for a period of twelve months unless the Member's licensed physician, licensed psychologist, or licensed clinical social worker determines a shorter period is appropriate or changes the results of the Member's diagnosis.

Behavioral Therapy

The term Behavioral Therapy means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder, that are: provided or under the supervision of an Autism Behavioral Therapy Provider.

Benefit Period

The length of time your Plan covers benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The "Important Notices about Your Benefits and Cost-Shares" under "What You Pay for Covered Services" 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 (Benefit 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 ha**s** been shown to have no clinically meaningful differences from the reference product.

Booklet

This document (also called the Benefit Booklet), which describes the terms of your benefits. It is part of the Plan offered by your Employer.

Brand Name Drugs

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

Centers of Medical Excellence (CME) 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 CME. To be a CME, 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 Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield 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.

Clinical Peer(s)

The term means a physician or other health care professional who:

1. holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, and
2. for an urgent care review concerning:
   a. a child or adolescent substance use disorder or a child or adolescent mental disorder, holds:
      - a national board certification in child and adolescent psychiatry; or
      - a doctoral level psychology degree with training and clinical experience in the treatment of child and adolescent substance use disorder or child and adolescent mental disorder, as applicable, or
   b. an adult substance use disorder or an adult mental disorder, holds:
      - a national board certification in psychiatry; or
      - a doctoral level psychology degree with training and clinical experience in the treatment of adult substance use disorders or adult mental disorders, as applicable.

A review for a substance use disorder with or without a co-occurring mental disorder, or for a mental disorder requiring (i) inpatient services, (ii) partial hospitalization, (iii) residential treatment, or (iv) intensive outpatient services necessary to keep a covered person from requiring an inpatient setting are considered an urgent care request.

Please refer to the “Getting Approval for Benefits” for specific Request Categories.

Clinical Trials

The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment, or palliation, or therapeutic intervention for the prevention of cancer, or disabling, or life-threatening chronic disease, in human beings, except that a clinical trial for the prevention of cancer, or disabling, or life-threatening chronic disease, is eligible for coverage only if it involves a therapeutic intervention and is conducted at multiple institutions. A Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved as outlined in the “What’s Covered Section”.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section).

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.

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

Covered Transplant Procedure

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

Custodial Care

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

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

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

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

Deductible

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

Dentally Necessary Orthodontic Care

A service for pediatric members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. See the Dentally Necessary Orthodontic Care benefit description in the “Orthodontic Care” section for more information.

Dependent

A member of the Subscriber’s family who meets the rules listed in the “Eligibility and Enrollment – Adding Members” section and who has enrolled in the Plan.

Designated Pharmacy Provider

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

Doctor

Please see the definition of “Physician”.

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the “What’s Covered” section.

Emergency Care

Please see the “What’s Covered” section.

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)

The term Experimental or Investigational means any drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service or supply used in or directly related to the diagnosis; evaluation; or treatment of a disease; injury; illness; or other health condition which Anthem determines to be Experimental or Investigational.

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

   The drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service or supply:

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

2. Any service not deemed Experimental or Investigational based on the criteria in subsection A. may still be deemed to be Experimental or Investigational by Anthem. In determining whether a service is Experimental or Investigational, Anthem will consider the information described in subsection C. and assess the following:

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

3. The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections A. and B. may include one or more items from the following list which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
- The written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply; or
- Medical records; or
- The opinions of consulting providers and other experts in the field.

4. Anthem will identify and weigh all information and determine all questions pertaining to whether a drug; biologic; device; diagnostic; product; equipment; procedure; treatment; service; or supply is Experimental or Investigational.

   Notwithstanding the above, services or supplies will not be considered Experimental if they have successfully completed a Phase III clinical trial of the Federal Food and Drug Administration, for the illness or condition being treated, or the diagnosis for which it is being prescribed.

   In addition, services and supplies for Routine Patient Care Costs in connection with a Cancer Clinical Trial will not be considered Experimental.

Facility

A facility including but not limited to, a Hospital, Ambulatory Surgery Center (Surgical Center), Residential Treatment Center, or Skilled Nursing Facility, as defined in this Booklet. 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 for coverage under this Plan.

Generic Drugs

Prescription Drugs that we classify as Generic Drugs or that our PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

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 must satisfy our accreditation requirements and be 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 showing 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 treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Late Enrollees

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

Maintenance Medications

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

Maintenance Pharmacy

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

Maximum Allowed Amount

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

Medical Necessity (Medically Necessary)

The terms Medically Necessary (Medically Necessary Care, Medical Necessity) mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, physician or other health care provider, and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

For the purpose of this subsection “not more costly” means services is cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member’s illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician’s office or the home setting.

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

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

Mobile Field Hospital

The term Mobile Field Hospital means a modular, transportable facility used intermittently, deployed at the discretion of the Governor, or the Governor's designee, for the purpose of training or in the event of a public health or other emergency for isolation care purposes or triage and treatment during a mass casualty event; or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure and is licensed as such by the State of Connecticut.

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 pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Fees, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn’t cover. Please see the “Schedule of Benefits” for details.

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

Participation in a Riot

Actively taking part in a violent disturbance involving two or more persons.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for the Plan's Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. Anthem's PBM, in consultation with Anthem, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician (Doctor)

Includes the following when licensed by law:

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

Optometrists, Clinical Psychologists (PhD), Doctors of Naturopathic Medicine (N.D.), 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.

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:

- 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.
- 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.

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.

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. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, Advanced Practice Registered Nurse (APRN), 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 when required by law that gives health care services within the scope of that license, must satisfy our accreditation requirements and be approved by us. Details on our accreditation requirements can be found at https://www.anthem.com/provider/ credentialing/. This includes any Provider that state law says we must cover when they give you Covered Services. Providers

that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Qualifying Payment Amount

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

Recognized Amount

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

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.

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

Residential Treatment Center / Facility

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

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

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

Retail Health Clinic

A Facility that gives limited basic health care services to Members without an appointment. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Routine Patient Care Costs

Routine Patient Care Costs in connection with Clinical Trials shall include Medically Necessary health care services that are incurred as a result of treatment rendered to a Member for purposes of a Clinical Trial that would otherwise be covered if such services were not rendered in conjunction with a Clinical Trial. Please see the “What’s Covered” section for details.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Site-of-Service Provider

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

- A Provider that is not part of or owned by a Hospital and bills independently (i.e. not under a hospital's name or ID number.) Providers such as Radiology Providers and Reference Laboratories meet these criteria and are considered "freestanding" Site-of-Service providers.
- An outpatient facility location owned by a Hospital that is contracted with Anthem and meets the criteria to be considered "Site-of-Service" ("SOS").

These entities provide health care services such as laboratory tests, radiology and other services that are typically lower cost options for patients. Each participating facility is subject to specific licensing, accreditation and credentialing requirements. Please see the "Schedule of Benefits" for applicable Cost-Shares depending on service(s) rendered, place of service, and your plan.

Skilled Nursing Facility

An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a skilled nursing facility in the state in which it is located, satisfy our accreditation requirements, and be approved by us.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

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.

Subscriber

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

Total Disability (or Totally Disabled)

The term Totally Disabled means that because of an injury or disease the Covered Person is unable to perform the duties of any occupation for which he or she is suited by reason of education, training or experience.

Transplant Benefit Period

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

Urgent Care Facility (Urgent Care Center)

A Facility or delivery system within the Emergency Department or a Medical Center licensed to take emergency transports, from whom Urgent Care services may be obtained. Urgent Care is a lower level of complexity than emergency care, in a hospital setting.

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.

Walk-In Center

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

Get Help in Your Language

Curious to know what all this says? We would be too. Here's the English version:

This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. 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)

Spanish

Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. 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

Ky njoftim përmban informacion të rëndësishëm rreth aplikimit ose përfitimeve tuaja. Shihni datat kryesore. Mund t'ju nevojitet të veproni brenda afateve të caktuara për të vazhduar të përfitoni ose për të menaxhuar kostot. 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)

Arabic

يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة (TTY/TDD:711).

Chinese

本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。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)

French

Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. 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)

Greek

Αυτή η ειδοποίηση περιέχει σημαντικές πληροφορίες για την εφαρμογή σας ή τις παροχές σας. Αναζητήστε τις σημαντικές ημερομηνίες. Ενδέχεται να χρειαστεί να κάνετε κάποιες ενέργειες μέχρι συγκεκριμένες ημερομηνίες, ώστε να διατηρήσετε τις παροχές σας ή να διαχειριστείτε το κόστος. 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)

Haitian

Avi sa a gen enfòmasyon enpòtan sou aplikasyon ou an oswa avantaj ou yo. Veye dat enpòtan yo. Ou ka bezwen pran aksyon avan sèten dat pou kenbe avantaj ou yo oswa jere depans ou yo. 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

इस सूचना में आपके आवेदन या लाभों के बारे में महत्वपूर्ण जानकारी है। महत्वपूर्ण तिथियाँ देखें। अपने लाभ बनाए रखने या लागत का प्रबंध करने के लिए, आपको निश्चित तिथियों तक कार्रवाई करने की ज़रूरत हो सकती है। 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)

Italian

Il presente avviso contiene informazioni importanti relative alla domanda da lei presentata o ai benefici a lei riservati. Consulti le date importanti riportate. Per continuare a usufruire dei benefici o ricevere assistenza per il pagamento delle spese, potrebbe dover eseguire determinate azioni entro scadenze specifiche. 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)

Korean

이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish

Niniejsze powiadomienie zawiera istotne informacje dotyczące wniosku lub świadczeń. Zwróć uwagę na ważne daty. Zachowanie świadczeń lub zarządzanie kosztami może wymagać podjęcia dodatkowych działań w konkretnych terminach. Masz prawo do bezpłatnego otrzymania stosownych 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

Este aviso contém informações importantes sobre a sua candidatura ou benefícios. Preste atenção a datas importantes. Poderá ser necessário agir até determinadas datas para manter os seus benefícios ou gerir os custos. 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)

Russian

Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. 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)

Tagalog

May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. 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)

Vietnamese

Thông báo này có thông tin quan trọng về đơn đang ký hoặc quyền lợi bảo hiểm của quý vị. Hãy tìm các ngày quan trọng. Quý vị có thể cần phải có hành động trước những ngày nhất định để duy trì quyền lợi bảo hiểm hoặc quản lý chi phí của mình. Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (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, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.