MEDICAL BENEFIT BOOK

For

Northern Buckeye Advantage HDHP Health Plan

ADMINISTERED BY

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

If You need assistance in Spanish to understand this document, You may request it for free by calling Member Services at the number on Your Identification Card.

EFFECTIVE 01/01/2023

CONSOLIDATED APPROPRIATIONS ACT OF 2021 NOTICE

Consolidated Appropriations Act of 2021 (CAA)

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

Surprise Billing Claims

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

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

No Surprises Act Requirements

Emergency Services

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

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

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

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

Out-of-Network Services Provided at a Network Facility

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

Post-stabilization

Post-stabilization consists of a four-part test:

1. The attending Physician determines that the Member is able to travel using nonmedical transportation to a Network Provider or Facility within a reasonable distance, taking into consideration the Member's medical condition;
2. The Network Provider/Facility satisfies notice and consent criteria;

3. The Member or their authorized representative must be in the condition to provide informed and voluntary consent; and
4. The Network Provider/Facility must satisfy any additional state law requirements.

Providers satisfy the notice and consent requirement as follows:

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

How Cost-Shares Are Calculated

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

Appeals

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

Provider Directories

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

Transparency Requirements

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

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

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

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

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

This Benefit Book provides You with a description of Your benefits while You are enrolled under the health care plan (the "Plan") offered by Your Employer. You should read this book carefully to familiarize Yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Book, please contact Your Employer's Group Health Plan Administrator or call the Claims Administrator's Member Services Department.

The Plan provides the benefits described in this Benefit Book only for eligible Members. The health care services are subject to the Limitations and Exclusions, Copayments, Deductible, and Coinsurance requirements specified in this

Benefit Book. Any group Plan or certificate which You received previously will be replaced by this Benefit Book.

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

Anthem Blue Cross and Blue Shield, or "Anthem" has been designated by Your Employer to provide administrative services for the Employer's Group Health Plan, such as claims processing, care management, and other services, and to arrange for a Network of health care Providers whose services are covered by the Plan.

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

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the State of Ohio. Although Anthem is the Claims Administrator and is licensed in Ohio, You will have access to Providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO Network across the country. Anthem has entered into a contract with the Employer on its own behalf and not as the agent of the Association.

Many words used in this Benefit Book have special meanings, like Covered Services, Network Provider, and Medical Necessity. These words are capitalized and are described in the Error! Reference source not found. section. See these definitions for the best understanding of what is being stated. Throughout this Book there may be references to "we," "us," "our," "You," and "Your." The words "we," "us," and "our" mean Anthem Blue Cross and Blue Shield. The words "You" and "Your" mean the Member, subscriber, and each Covered Dependent.

Verification of Benefits
Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Member Services with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 6:00 p.m. Eastern Time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. CALL THE MEMBER SERVICES NUMBER ON YOUR IDENTIFICATION CARD or see the section titled **Health Care Management for Precertification** rules.

Identity Protection Services
If You are enrolled in an Anthem medical plan You automatically receive a basic level of Identity Repair Services and can voluntarily enroll in Credit and Identity Theft Monitoring Services, at no cost to You. To learn more about these services, please visit https://anthemcares.allclearid.com/.

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NORTHERN BUCKEYE HEALTH PLAN KEY INFORMATION

IMPORTANT NETWORK CONTACT INFORMATION:

Function	Network Name	Claims Filing Information	Phone Number	URL
PPO Network	Anthem	Mailing Address: PO Box 105187 Atlanta GA 30348-5187	1-833-592-9954	www.anthem.com
Prescription Benefit Manager	Express Scripts	PO Box 66583, St. Louis, MO 63166	1-866-275-0044	www.express-scripts.com
Utilization Review/Pre-certification Firm	Anthem	Mailing Address: PO Box 105187 Atlanta GA 30348-5187	Medical/Surgical: 1-866-643-7087 Behavioral Health: 1-866-643-7087	www.anthem.com

INDIVIDUALS ENTITLED TO ACCESS PROTECTED HEALTH INFORMATION UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA):

The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the protected health information (PHI) to be disclosed:

a. The following persons under control of the Plan Sponsor shall be given access to the PHI: Chief Administrator, and all other staff designated by the Chief Administrator.

b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan's Privacy Officer shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs.

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member You have rights and responsibilities when receiving healthcare. As Your healthcare partner, we want to make sure Your rights are respected, while providing Your health benefits. That means giving You access to our network of Doctors and healthcare professionals, who help You make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

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

You have the responsibility to:

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

If You would like more information, have comments, or would like to contact us, please go to anthem.com and select Contact Us. Or call the Member Services number on Your Identification Card.

We are here to provide high quality benefits and service to our Members. Benefits and coverage for services given under the Plan are overseen by Your Certificate of Coverage, Member Handbook, or Schedule of Benefits-and not by this Member Rights and Responsibilities statement.

How to Obtain Language Assistance

Anthem is committed to communicating with our Members about their health Plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our Member Services Call Centers. Simply call the Member Services phone number on the back of Your Identification Card and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested 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.

SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the **Definitions** and **Claims Payment** sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

The Federal No Surprises Act establish patient protections including from Out-of-Network Providers' surprise bills ("balance billing") for Emergency Care and other specified items or services. We will comply with these new Federal requirements including how we process claims from certain Out-of-Network Providers. The Federal requirements are described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Book. 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.

To receive maximum benefits at the lowest Out-of-Pocket expense, Covered Services must be provided by a Network Provider. Covered Services received from any other Network Provider are covered at the Network level but require a higher Copayment / Coinsurance than a Network Provider.

Welcome to the Health Savings Account (HSA) Plan!

The HSA Plan administered by **the Claims Administrator** is an innovative approach to health benefits for eligible Employees of **Northern Buckeye Health Plan** (the company).

With the HSA plans, You have health coverage available to You for which You and the company share the cost. This coverage has two components designed to work together to provide You flexibility and control in choosing the health care services You and Your family members receive and in choosing how the cost of these services is paid. Bottom line, the plans are designed to help You – and Your family – take control of Your health care dollars and decisions.

How the HSA Plan Works

The HSA Plan is an innovative approach to health benefits that puts You in charge of the money You spend for health care services and helps You get the most out of Your company-sponsored health coverage. With the HSA Plan, You have flexibility and control in choosing the health care services You and Your family members receive – and in determining how the cost of these services is paid.

The HSA Plan – In Brief

First – Using Your HSA to pay for Covered Services:

Health Savings Account
With the Health Savings Account (HSA), You can contribute pre-tax dollars to Your HSA. Others may also contribute dollars to Your account. You can use the dollars to help meet Your annual Deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

Plus – To help You stay healthy, use:
Preventive Services
100% coverage for nationally recommended services using Network Providers.

No deductions from the HSA or Out-of-Pocket costs for You as long as You receive Your preventive care from a Network Provider. If You choose to go to an Out-of-Network Provider, Your Deductible or Traditional Health Coverage benefits will apply.

If needed:

Traditional Health Coverage
Traditional Health Coverage is made available by Your Employer on a self-funded basis and helps to protect You and Your family in case You have significant health care expenses. Coverage is effective once You have met an up-front Out-of-Pocket cost for covered expenses (Your Deductible). Once coverage is effective, the Plan will reimburse a percentage of the cost for Covered Services. You will be responsible for covering the remainder of the expense of Covered Services, up to an annual Out-of-Pocket Maximum. After this amount has been met, You will receive coverage for Covered Services for the remainder of the Plan year as specified elsewhere in this Benefit Booklet. The Traditional Health coverage is governed by the details contained elsewhere in this document.

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

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

Financial Tools

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

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the maximum amount the Plan will pay for a given service. All payments are based on the Maximum Allowed Amount and any negotiated arrangements. Except for Surprise Billing Claims, if You use an Out-of-Network Provider, You are responsible for any balance due between the Out-of-Network Provider's charges and the Maximum Allowed Amount in addition to any Coinsurance, Deductibles and non-covered changes. Depending on the service, this difference can be substantial.

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

Contributions to Your HSA

For 2023 , contributions can be made to Your HSA up to the following:

Contributions to Your HSA	
Individual Coverage	$3,850
Family Coverage	$7,750

Schedule of Benefits	**Network**	**Out-of-Network**
Calendar Year Deductible		
Individual	$3,000	$3,200
Family	$5,000	$6,000
Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.		
All Covered Services are subject to the Deductible unless otherwise specified in this book		
Your Plan has an embedded Deductible which means: • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You.		

Schedule of Benefits	Network	Out-of-Network
• If You also cover Dependents (other family Members) under this Plan, both the “Individual” and the “Family” amounts apply. The “Family” Deductible amounts can be satisfied by any combination of family Members but You could satisfy Your own “Individual” Deductible amount before the “Family” amount is met. You will never have to satisfy more than Your own ‘Individual” Deductible amount. If You meet Your “Individual” Deductible amount, Your other family Member’s claims will still accumulate towards their own “Individual” Deductible and the overall “Family” amounts. This continues until Your other family Members meet their own “Individual” Deductible or the entire “Family” Deductible is met.		
Amounts satisfied toward the Network calendar year Deductible will be applied toward the Out-of-Network calendar year Deductible and amounts satisfied toward the Out-of-Network calendar year Deductible will be applied toward the Network calendar year Deductible.		
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)		
Plan Pays	80%	70%
Member Pays	20%	30%
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. Except for Surprise Billing Claims, if You use Out-of- Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges. Depending on the service, this difference can be substantial.		
Out-of-Pocket Maximum Per Calendar Year		
(Includes Coinsurance, Medical and Pharmacy Copayments and the Calendar Year Deductible.) Does NOT include services deemed not Medically Necessary by Medical Management and/or Anthem, Penalties for Non- Compliance, Charges in Excess of the Maximum Allowed Amount or Non-Covered Services.		
Individual	$4,500	$5,000
Family	$7,700	$9,000
Your Plan has an embedded Out-of-Pocket which means: • If You, the Subscriber, are the only person covered by this Plan, only the “Individual” amounts apply to You. • If You also cover Dependents (other family Members) under this Plan, both the “Individual” and “Family” amounts apply. The “Family” Out-of-Pocket amounts can be satisfied by any combination of family Members but You could satisfy Your own “Individual” Out-of-Pocket amount before the “Family” amount is met. You will never have to satisfy more than Your own “Individual” Out-of-Pocket amount. If You meet Your “Individual” amount, other family Member’s claims will still accumulate towards their own “Individual” Out-of-Pocket and the overall “Family” amounts. This continues until Your other family Members meet their own “Individual” Out-of-Pocket or the entire “Family” Out-of-Pocket is met.		
The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined.		

Benefits	Network	Out-of-Network
Allergy Care		
• Testing and Treatment – Physician or Specialist Physician	80%	70%
***Member responsibility per office visit for Network services is the Copayment or the actual charge, whichever is less.**		
Ambulance Services		
• Air Ambulance Services (when Medically Necessary) • Ground Ambulance Services (when Medically Necessary)	80% 80%	80% 80%
Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. Refer to the **Health Care Management-Precertification** section for more information.		
Note: If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		
Behavioral Health/Substance Abuse Care		
• Inpatient Admission Coinsurance ► Institutional Behavioral Health /Substance Abuse Inpatient Services — Precertification Required ► Includes Detox, Residential Treatment, Eating Disorders and Methadone Clinics.	80%	70%
• Inpatient Professional Behavioral Health/ Substance Abuse and Detox Services	80%	70%
• Outpatient Behavioral Health and Substance Abuse Services — Applied only to visits and consultations. ► Includes Methadone Clinics and eating disorders	80%	70%
• Intensive Outpatient Therapy (IOP), Eating Disorders, Methadone Clinics and Partial Hospitalization (PHP) Services (Online visits are covered.)	80%	70%
• Treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)	Covered at the benefit level of services billed	Covered at the benefit level of services billed
► Includes autistic disease, mental retardation, Developmental Delays and learning impairments.	80%	70%
► Physician Services (In-person and/or virtual) Including Online Visits are covered and mirror the professional office Mental Health visit benefit.	80%	70%
► Applied Behavioral Analysis (ABA) Therapy through age of 14 years old	80%	70%
**Not Subject to Deductible		

Benefits	Network	Out-of-Network
Members with mental health or substance abuse conditions (including opioid-use disorders) have access to individual case management programs as detailed under "Health Plan Individual Case Management" in the section **Health Care Management - Precertification**. These programs include coordination of services for high risk Members with opioid-use disorder or opioid disorders. Also, refer to the **Health Care Management - Precertification** section for any Precertification and review requirements. This section defines what services, which include treatment of opioid abuse, qualify for an urgent review based on State and Federal laws. To get additional information for opioid education and related issues please go to www.anthem.com and enter "opioid" in the search box. **Note: Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with Federal law.**		
Clinical Trials See Clinical Trials under **Benefits** section for further information.	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Dental & Oral Surgery/TMJ Services		
• Accidental Injury to Natural and Sound Teeth	Covered at Network Benefit Level of Services Billed	Covered at Out-of-Network Benefit Level of Services Billed
• Oral Surgery ► Dental anesthesia is covered only if related to a payable oral surgery.	Covered at Surgical Level	Covered at Surgical Level
► TMJ Treatment Appliances are not covered.	Not Covered	Not Covered
Diagnostic Physician's Services		
• Diagnostic Physician Office Services	80%	70%
• Non-Specialist/Specialist	80%	70%
• Office / Home Visits	80%	70%
• Consultation / Second Surgical Opinion	80%	70%
• Retail Health Clinic	80%	70%
• Office Surgery (including anesthesia)	80%	70%
• Injections ► Includes administration charge and B-12 injections.	80%	70%
• Non-Routine diagnostic X-ray and Lab Services (Office and Independent Lab)	80%	70%
Diagnostic Non-Routine MRI, CAT, PET Scans	80%	70%
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury. Telehealth/Telephonic Benefits are based on the setting in which Covered Services are received.		

Benefits	Network	Out-of-Network
Emergency Services and Urgent Care		
• Institutional Emergency Room Services for Emergency Medical Conditions	80%	80%
• If Emergency Room Physician for an Emergency Medical Condition	80%	80%
• Urgent Care Institutional and Professional Services Copayment	80%	70%
Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. As described in the **Consolidated Appropriations Act of 2021 Notice** at the front of this Benefit Book, Out-of-Network Providers may only bill You for any applicable Copayments, Deductible and Coinsurance and may not bill You for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined You are stable. Please refer to the Notice at the beginning of this Benefit Book for more details.		
Eye Care		
• Non-Routine Medical Vision Non-Specialist/ Specialist Exam Coinsurance	80%	70%
Gender Affirming Surgery • Precertification required for all surgical procedures	Benefits are based on the setting in which Covered Services are received.	
Gene Therapy Services • Precertification required	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Hearing Exam		
• Non-Routine Medical Hearing Non-Specialist / Specialist Exam	80%	70%
• Hearing Aid Services	Not Covered	Not Covered
Home Health Services		
• Home Health Services ► Private duty nursing is only covered in the home ► Includes Home Infusion Therapy	80%	70%

Benefits	Network	Out-of-Network
Hospice Care		
• Hospice Services ► Includes respite care ► Applies to inpatient and outpatient Hospice	80%	70%
Except for Surprise Billing Claims, Out-of-Network Providers may also bill You for any charges over the Plan's Maximum Allowed Amount.		
Hospital Inpatient Services		
• Inpatient Admission Coinsurance	80%	70%
► Institutional Inpatient Services — Precertification Required • Room and Board • (Semi-private or ICU/CCU) • Hospital Services and Supplies (X-ray, lab, anesthesia, surgery, Inpatient institutional therapy services, maternity, etc.	80%	70%
• Inpatient Physical Medical Rehabilitation	80%	70%
• Professional Inpatient Services		
► Surgeon (Cosmetic, Reconstructive Surgery) — Subject to Medical Necessity	80%	70%
► Assistant Surgeon — Covered if Medically Necessary	80%*	70%*
► Inpatient Medical Care (Includes general medical care, consultation, second opinion, intensive care monitoring and newborn care.)	80%	70%
► Anesthesiologist	80%*	70%*
► Diagnostic X-rays and Laboratory Tests	80%*	70%*
► Inpatient Therapy Services (Includes chemotherapy, radiation therapy, dialysis, hemodialysis, infusion therapy, Physical Therapy, occupational therapy, speech therapy and respiratory therapy.)	80%	70%
► Non-routine diagnostic MRI, CAT, PET Scans	80%	70%
*Hospital Based Provider services rendered by non-participating Providers are covered at the Network Benefit Level.		

Benefits	Network	Out-of-Network
Maternity Care & Other Reproductive Services		
• Global Care (Includes pre and post-natal delivery and therapeutic abortions.) ► Dependent daughters are covered.	80%	70%
• Contraceptives — Covered for medical conditions. ► Contraceptives for women will be covered under "Preventive Care". Please see that section in **Benefits** for further details.	Covered at Benefit Level of Services Billed	Covered at Benefit Level of Services Billed
• Voluntary Sterilization Services (Precertification required for Inpatient procedures.) Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section in **Benefits** for further details. Reversal of voluntary sterilization is not covered. ► Vasectomy	Covered at Benefit Level of Services Billed	Covered at Benefit Level of Services Billed
Note: Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48-hours for a vaginal delivery or 96-hours for a cesarean section, must be pre-certified		
Medical Supplies and Equipment		
• Durable Medical Equipment ► Purchase and Rental (if not included with office visit)	80%	70%
• Medical Supplies	80%	70%
• Diabetic Supplies ► Diabetic supplies covered by Pharmacy plan are not covered under medical including lancets, syringes, insulin, etc. Diabetic supplies not covered under Pharmacy are covered by the medical plan.	80%	80%
• Prosthetics and Orthotics ► Includes initial glasses or contact lenses after cataract surgery. ► Including wig and toupees Needed After Cancer Treatment Benefit Maximum One wig and toupees per Benefit Period Network and Out-of-Network combined. ► Includes foot orthotics, based on Medical Necessity. ► Including Cochlear Implants ► Including Bone Anchored Hearing Aids	80%	70%
Nutritional Counseling		
► Nutritional Counseling for Diabetes When part of Health Care Reform, please see "Preventive Care" benefit.	80%	70%

Benefits	Network	Out-of-Network
Obesity Services		
• Obesity Services ► Includes surgical treatment (when Medically Necessary)	Covered at Benefit Level of Services Billed	Covered at Benefit Level of Services Billed
Outpatient Hospital/Facility Services		
• Institutional Clinic Services	80%	70%
• Outpatient Hospital Services / Ambulatory Surgery Copayment	80%	70%
• Surgeon	80%	70%
• Assistant Surgeon — Covered if Medically Necessary.	80%*	70%*
• Anesthesiologist	80%*	70%*
• Non-routine Diagnostic Laboratory and X-ray Services	80%**	70%
• Diagnostic Non-Routine MRI, CAT and PET Scans	80%	70%
• Pre-Surgical / Pre-Admission Testing	80%	70%
• Outpatient Consultation / Second Opinion	80%	70%
*Hospital based Provider services rendered by non-participating Providers are covered at the Network benefit level. **Not Subject to Deductible		
Physician Services (In-person and/or virtual)		
• Primary Care Physician Coinsurance (In-person and/or virtual)	80%	70%
• Specialist Physician Coinsurance (In-person and/or virtual)	80%	70%
• **Telehealth** - Consultations with Your physician (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet)	80%	70%
• **Telephonic** - Consultations with Your physician (PCP/Specialist) using audio only (telephone)	80%	70%
• **LiveHealth Online –** Virtual visits from Out-of-Network Online Providers (whether accessed directly or through our mobile app.)	80%	Not Covered
Prescription Drug Benefit – Refer to the Prescription Drug Covered Services section at the end of the book		

Benefits	Network	Out-of-Network
Preventive Services – Refer to Preventive Services under Benefits section		
• Preventive Services (Regardless of Provider or setting where Preventive Care is provided) **Not Subject to Deductible	100%**	Covered at Non-Routine Benefit Level
Skilled Nursing Facility		
• Skilled Nursing Facility Services — Precertification Required • Maximum 60 Days per calendar year combined Network and Out-of-Network	80%	70%
Smoking / Tobacco Cessation		
• Smoking / Tobacco Cessation Services When medically necessary	80%	70%
Therapy Services (Outpatient)		
• Physical Therapy ► Limited to a combined 62 visits per calendar year for Physical therapy, Occupational therapy, and Speech therapy per benefit period. Network Providers and Non-Network Providers combined.	80%	70%
• Speech Therapy (Developmental speech therapy is **not** covered under the speech therapy benefit.) ► Limited to a combined 62 visits per calendar year for Physical therapy, Occupational therapy, and Speech therapy per benefit period. Network Providers and Non-Network Providers combined.	80%	70%
• Biofeedback– Medical Necessity only and licensed provider	80%	70%
• Manipulation Therapy ► Limited to 62 visits per calendar year for all services performed by a licensed Provider; Network and Out-of-Network combined.	80%	70%
• Cardiac Rehabilitation	80%	70%
• Chemotherapy	80%	70%
• Dialysis / Hemodialysis	80%	70%
• Infusion Therapy	80%	70%
• Occupational Therapy ► Limited to a combined 62 visits per calendar year for Physical therapy, Occupational therapy, and Speech therapy per benefit period. Network Providers and Non-Network Providers combined.	80%	70%

Benefits	Network	Out-of-Network
• Radiation Therapy	80%	70%
• Blood Therapy — Processing and Storage	80%	70%
• Respiratory Therapy	80%	70%

Benefits		Network	Out-of-Network
Transplant Schedule Of Benefits	**BDCT Facility Blue Distinction Centers of Medical Excellence**	**(Network)**	**(Out-Of-Network)**
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.			
Transplants			
Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy. **The Blue Distinction Centers of Medical Excellence requirements do not apply to** Cornea and Kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. **Note:** Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as a Network Transplant Provider by the Blue Cross and Blue Shield Association. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.) **Centers of Medical Excellence (CME) Transplant Providers** **Blue Distinction Center Facility**: Blue Distinction Facilities have met or exceeded national quality standards for care delivery. **Centers of Medical Excellence (CME**): Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery. **Network Transplant Provider:** Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. **Out of Network (PAR) Transplant Provider:** Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.			
• **Organ Transplants** — Institutional and Professional Services — Precertification Required ► Donor expenses are covered.	100%**	80%	Not Covered
• **Live Donor Health Services** ► Donor benefits are limited to benefits not available to the donor from any other source. Medically Necessary charges for the procurement of an organ from a live donor are covered up to Maximum Allowed Amount, including complications.	100%**	80%	Not Covered

Benefits	Network		Out-of-Network
• **Bone Marrow Donor Search Fee** ► Limited to $30,000 per transplant	100%**	80%	Not Covered
• **Travel and Lodging for Organ Transplants** ► $10,000 maximum per transplant ► $50 lodging maximum per day for double occupancy	100%**	80%	Not Covered
**Not Subject to Deductible			

TOTAL HEALTH AND WELLNESS SOLUTION

ConditionCare Programs

ConditionCare programs help maximize Your health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult).
- Diabetes (pediatric and adult).
- Heart failure (HF).
- Coronary artery disease (CAD).
- Chronic obstructive pulmonary disease (COPD).

You'll get:

- 24/7 phone access to a nurse coach who can answer Your questions and give You up-to-date information about Your condition.
- A health review and follow-up calls if You need them.
- Tips on prevention and lifestyle choices to help You improve Your quality of life.

Sydney Health App

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

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

Working with You

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

Planning and tracking Your health goals, fitness, and rewards

ELIGIBILITY

Employee (also referred to as a Subscriber and/or Member)

An "Employee" is an individual who meets the eligibility requirements of the Employer Group. This includes working the 15 hours the Employer Group requires for eligibility. This also includes Board Members or other individuals who are required to be covered by State or Federal Law, regardless of hours worked.

An Employee is eligible to enroll in the Plan if 1) You work for a participating Employer Group and You are a member of a group of Employees designated by Your participating Employer Group as eligible to participate, 2) You are a full-time Employee, a Board Member or a Trustee of the Northern Buckeye Health Plan, NW Division of OHI, or 3) Your Employer is contracted by the Trust to provide Chief Administrator support and/or services. NOTE: This Plan does not cover Retirees as an eligibility class or their Dependents.

Employee Coverage

An Employee must submit enrollment elections within 60 days from the date the Employee becomes newly eligible for benefits. An Employee is eligible on their employment start date or date defined by their Employer Group. If the Employee does not enroll when newly eligible, the Employee will be required to wait until the next Open Enrollment period, unless the Employee has a Qualified Change in Status event.

Eligible Dependent (also referred to as a Member) includes the following:

Spouse: A "Spouse" generally includes any individual lawfully married to the Employee under State Law. Marriage is defined by the Plan as 1) a legal union between one man and one woman as husband and wife, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage or 2) a legal union between two individuals of the same sex, legally married in a jurisdiction (domestic or foreign) that recognizes their marriage. Marriage does not include a civil union, domestic partnership or any other similar arrangement, nor does it include a legally separated Spouse.

Child or Children: A "Dependent Child" or "Dependent Children" includes Your natural-born Children, legally adopted Children from the date the Employee assumes legal responsibility, foster Children that live with the Employee and for whom the Employee is the primary source of financial support, Children for whom the Employee assumes legal guardianship, and step Children. Also included are the Employee's Children (or Children of the Employee's Spouse) for whom the Employee has legal responsibility resulting from a valid court decree. Subject to the following exception, Dependent Children are generally considered eligible Dependents through the end of the month in which they attain age 26.

Child with an Impairment: A Dependent Child who is mentally and/or physically impaired and already enrolled in the Plan upon turning age 26 may be eligible to continue to be a covered Dependent if the Child meets all of the following eligibility criteria;

- Unmarried
- Living with the Employee
- Mentally and/or physically incapable of sustaining employment and/or earning his/her own living
- Totally dependent on the Employee for support
- Completes the Certificate of Impairment form and receives approval from Anthem for continued coverage. NOTE: The Certificate of Impairment must be completed within 60 days of the Child turning age 26 and may be required periodically as deemed necessary by Anthem.

You must notify the Plan or Claims Administrator if Your Dependent has a change in marital or tax exemption status and is no longer eligible for continued coverage.

Dependent Coverage

The request of the Employee to enroll a Dependent must be submitted within 60 days from the date a Dependent became eligible to enroll in the Plan. Required eligibility verification documents must also be provided within 60 days from the date a Dependent became eligible. If the Employee does not enroll the Dependent at this time, the

Employee will be required to wait until the next Open Enrollment period, unless the Dependent has a Qualified Change in Status event.

Spouse
A Spouse is eligible to enroll in this Plan for primary coverage when the Spouse meets one of the following criteria:

- The Spouse is not eligible for an employer-sponsored or a retiree group medical plan (and is not entitled to employment-related funds or stipends for the purchase of individual/exchange coverage)
  - A Spouse eligible for an employer-sponsored or retiree group medical plan (including but not limited to STRS, SERS, OPERS, Police/Fire, etc.) must take that coverage on an individual basis as primary insurance. This Plan may then be secondary.
  - A Spouse receiving funds or stipends by a former or current employer must use those funds to enroll or purchase primary coverage on an individual basis as primary insurance. This Plan may then be secondary.
- The Spouse is eligible for an employer-sponsored or retiree group medical plan but would have to pay more than 50 percent of the total premium for single coverage of the lowest cost option available to them. For those entitled to employment-related funds or stipends, the cost of individual/exchange coverage is reduced by the value of the funds/stipend.
  - Premium does NOT include spousal waiver incentives or other such additional compensation forfeited upon enrollment in their plan.
- The Spouse is unemployed or self-employed.
- The Spouse is retired and only eligible for a government sponsored Plan (Medicare/Tricare).

FAILURE TO COMPLY MAY RESULT IN PENALITIES AND/OR DISMISSAL FROM THE PLAN
When this Plan is secondary, the Employee will be required to submit the primary coverage information for the Spouse provided through their employer-sponsored or retiree group medical plan for proper Coordination of Benefits. The Employee is required to provide primary coverage information for the Spouse upon initial enrollment, on an annual basis through Open Enrollment, and periodically as deemed necessary. The Employee may provide the primary coverage information through completion of the Spousal Employer Verification Form, if requested. Such information may include, but is not limited to, employment verification, Employer health plan offerings and documentation, retirement status and related material. Until all required documentation has been received and approved by the Claims Administrator, any claims for the Spouse will be denied and returned to the sender.

Children (Under 26 years of Age)

If You have family coverage, Your newly eligible Dependent Child becomes eligible for coverage from the moment the Child qualifies, provided You actually enroll the newly eligible Dependent Child in Your coverage within 60 days of the qualifying event.

A newly eligible Dependent Child is permitted to obtain coverage retroactively from the moment of birth, adoption, or for whom You assume legal responsibility, even if after the 60-day enrollment period. However, no claims will be processed for the newly eligible Dependent Child until the enrollment record is received and all verification documents are provided and approved.

Open Enrollment Period

Each Calendar Year, a period of time may be designated as an Open Enrollment period. Except for a Qualified Change in Status, if applicable, it is only during this time an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. Coverage will be effective on January 1st of the following year.

Qualified Change in Status

If You fail to enroll during an Open Enrollment period, You may be able to make a mid-year election if You experience a "Qualifying Change in Status." Any mid-year election change or revocation You make must be on account of and consistent with the qualified change in status event that You experience. When a qualified change in status occurs, You may revoke an election for the balance of a period of coverage and make a new election only if both the revocation and the new election are due to and consistent with the qualified change in status. The Plan Administrator has the sole discretionary authority to determine whether the requirements for revocation and a new election have been satisfied and any such determination by the Plan Administrator shall be final and binding. A "qualified change in status" event that may impact You or Your Dependent's eligibility for coverage under the Plan can include one or more of the following:

- Marital Status. (e.g. marriage, divorce, legal separation, annulment, death of Spouse).
- Number of Children who are Dependents. (e.g., due to birth, death, adoption, placement for adoption or foster care).
- Employment Status. An event that changes the employment status (including worksite) of You or Your Dependents that causes You or Your Dependents to either gain or lose eligibility for an employer's benefit program (e.g., starting or ending a job; strike or lockout; starting or ending an unpaid leave of absence; change in worksite; job classification change such as full-time to part-time or vice versa, etc.).
- Residence. A change in the place of residence of You and/or Your Dependent that removes You and/or Your Dependent from the Plan's service provider area. This change entitles You to select another coverage option, but does not permit You to opt out of coverage entirely, unless, as a result of the move, You or Your Dependent are no longer eligible for coverage.
- Dependent Eligibility. A change that causes an individual to satisfy or cease to satisfy the requirements to be a Dependent (e.g., attaining a particular age, gaining or losing student status, if applicable, a change in Plan eligibility requirements).
- Cost or Coverage. A significant change in Plan costs or coverage (e.g., new benefit option added; benefit option eliminated or significantly curtailed; coverage change under another employer's plan that allows participants to make mid-year election changes; and significant increase in the cost of a benefit) (permits You to make a new benefit selection, but does not allow You to revoke coverage entirely, unless no other similar coverage is available).
- Medicare/Medicaid. If You or Your Dependents become entitled to or ineligible for Medicare (Part A or B) or Medicaid coverage (other than coverage consisting solely of coverage for pediatric vaccines).
- FMLA. If You begin or return from an unpaid leave pursuant to the Family and Medical Leave Act.
- Open Enrollment. If You or Your eligible Dependent elect coverage during an open enrollment period that differs in time from the annual open enrollment period offered by the Plan.
- Court Order. A duly executed judgment, decree or order (including a QMCSO), resulting from a divorce, legal separation, annulment or change in legal custody that requires health coverage for Your child (including Your adopted child) who is Your Dependent (coverage previously elected by You may be dropped only if the other individual actually provides coverage for the child).
- HIPAA. If You and/or Your Dependents are enrolling for group health coverage pursuant to special enrollment rules under HIPAA.

- CHIPRA. If You or Your Dependents lose Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") coverage due to no longer being eligible for those benefits, or You and/or Your Dependent become eligible for premium assistance in the Plan under CHIPRA.

- Reduction in Hours Worked. If You have a reduction in Your regular hours worked to less than 30 hours per week on average, but such reduction in hours does not cause You to lose Your Plan coverage. You and any other Dependent covered by the Plan must intend to enroll in another medical program that provides "minimum essential coverage" as defined by the ACA, and such coverage must be effective no later than the first day of the second month following the month during which You terminate Your coverage under the Plan.

- Eligibility for an Exchange Plan. If You become eligible to enroll in a medical program through an "American Health Benefit Exchange" (as defined in the ACA), also known as a Health Insurance Marketplace (the "Exchange"); and You, and any other individual(s) for whom You elected Plan coverage intend to enroll in a medical program through the Exchange that is effective no later than the day following Your last day of coverage under this Plan.

- Any such other events as may be permitted under the Treasury Regulations.

Generally, you must change or revoke your election within 60 days after the change in status. The change or revocation will be effective as soon as is administratively practicable after it is received by the Plan Administrator, but in no event earlier than the first pay period beginning after a new election is completed and returned to the Plan Administrator. Changes in elections due to a qualified change in status will only be effective as to contributions and benefits under the Plan on and after the effective date of such change. However, election changes made due to a special enrollment right as provided by HIPAA may result in coverage being made available retroactively to the date of the qualified change in status.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, impairment, sexual orientation or identity, gender, or age.

OBRA 1993 and Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted Children and Children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent Child includes:

- An adopted Child, regardless of whether or not the adoption has become final.

- An "adopted Child" is any person under the age of 18 as of the date of adoption or placement for adoption. "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a Child to be adopted. Placement ends whenever the legal support obligation ends.

- A Child for whom an Employee has received an MCSO (a "Medical Child Support Order") which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order ("QMCSO").

- Upon receipt of a QMCSO, the Employer or Plan Administrator will inform the Employee and each affected Child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Employee and the Child(ren) of the determination.

- A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Unpaid Leave - Continuation of Coverage Policy

After the Employee has exhausted all paid leave with benefits, and/or is no longer paid by the Employer, the Employee is now on “unpaid leave with benefits.” The Plan will provide “unpaid leave with benefits coverage for a maximum of 12 weeks annually. The annual 12-month period is measured forward from the start date of the unpaid leave period. When coverage ends under the Plan following the 12-week period of unpaid leave with benefits, the Employee is eligible for COBRA continuation of coverage.

Notwithstanding the foregoing, the Plan Administrator may, in its sole discretion and on a nondiscriminatory basis, elect to extend coverage during an unpaid leave period beyond the annual 12-week unpaid leave with benefits coverage continuation period in extraordinary circumstances (e.g., including but not limited to pandemics, when necessary or appropriate for administrative purposes, etc.). The Plan does not require unpaid leave to qualify as FMLA leave or military leave in order to be considered an eligible unpaid leave with benefits period. However, if such unpaid leave does qualify as FMLA leave or military leave, such leave period will be subject to any additional requirements set forth in the book that apply to FMLA/military leave periods. Further, any period of unpaid leave with benefits described above will run concurrently with any unpaid FMLA or military extension of coverage

HOW YOUR PLAN WORKS

Note: Capitalized terms such as Covered Services, Medical Necessity and Out-of-Pocket Limit are defined in the “Definitions” Section.

Introduction

Your health Plan is a Preferred Provider Organization (PPO) which is a comprehensive Plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out- of-Pocket expenses will be higher when You use Out-of-Network Providers. To find a Network Provider for this Plan, please see “How to Find a Provider in the Network,” later in this section.

Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

Network Services

When You use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has the final authority to decide the Medical Necessity of the service.

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

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

To see a Doctor, call their office:

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

When You go to the office, be sure to bring Your Member Identification Card with You. For services from Network Providers:

1. You will not need to file claims. Network Providers will file claims for Covered Services for You. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by Your Network Provider(s) for any Non-Covered Services You get or when You have not followed the terms of this Benefit Book.
2. Precertification will be done by the Network Provider. (See the **Health Care Management – Precertification** 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 a Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Book.

For services from an Out-of-Network Provider:

- There is no limit to what an Out-of-Network provider can charge unless Your claim involves a Surprise Billing claim
- The Out-of-Network Provider may charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments unless Your claim involves a Surprise Billing claim;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments) unless Your claim involves a Surprise Billing claim;
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see **Health Care Management**
- **– Precertification** for more details.)

Surprise Billing Claims

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

Use the Mobile App to Connect with Us

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

How to Find a Provider in the Network

There are three 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 Network Providers at www.anthem.com or on the Sydney Health App, which lists the Doctors, Providers, and Facilities that participate in this Plan's Network.
- Call Member Services to ask for a list of doctors and Providers that participate in this Plan's Network, based on specialty and geographic area.
- Check with Your doctor or Provider.

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

Continuity of Care

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

- An ongoing course of treatment for a life-threatening condition.
- 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.
- An ongoing course of treatment for a health condition for which the Physician or healthcare Provider attests that discontinuing care by the current Physician or Provider would worsen Your condition or interfere with anticipated outcomes.

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

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

The BlueCard Program

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

Calendar Year Deductible

Before the Plan begins to pay benefits (except certain benefits which are subject to Copayment instead of Deductible), You must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the **Schedule of Benefits**. Deductible requirements are stated in the **Schedule of Benefits.**

HEALTH CARE MANAGEMENT – PRECERTIFICATION

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

Reviewing Where Services are Provided

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

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

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

If You have any questions about the Utilization Review process, the medical policies, or clinical guidelines, You may call the Member Services telephone number on Your Identification Card or visit www.anthem.com.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if the Plan decides Your services are Medically Necessary. For benefits to be covered, on the date You get service:

1. You must be eligible for benefits;
2. Fees must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under this book;
4. The service cannot be subject to an Exclusion under this book; and
5. You must not have exceeded any applicable limits under Your Plan.
6. Additionally, Your claim must be received by us within the timeframes specified in the Notice of Claim & Proof of Loss provision in the Claims Payment section of this book. Please note that if the covered service is received from an Out-of-Network Provider or a provider that is not authorized by us, You may also still be liable for all or part of the claim.

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. Please contact us at the customer service telephone number on the back of Your Identification Card to determine if a Prior Approval or a Precertification is required. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Benefit Book.

  For admissions following Emergency Care, You, Your authorized representative or Doctor should tell the Claims Administrator no later than 2 business days after admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal

delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.

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

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

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

Precertification Penalties:

- **No Precertification on File –** If claims that require precertification are not pre-certified, they will be denied for no precertification. Once information is received claims can be reopened based on medical information provided.
  - **Late Notice** - $500
- **Not Medically Necessary –** Any services or days found not to be Medically Necessary will not be covered.

Services and Treatments That Require Precertification

The following list is not all inclusive and is subject to change; please call the Member Services telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.

Inpatient Admission:

- Acute Inpatient
- Acute Rehabilitation
- LTACH (Long Term Acute Care Hospital)
- Skilled Nursing Facility
- OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)
- Emergency Admissions (Requires Plan notification no later than 2 business days after admission)

Diagnostic Testing:

- Cardiac Ion Channel Genetic Testing
- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Gene Mutation Testing for Solid Tumor Cancer Susceptibility and Management
- Genetic Testing for Breast and/or Ovarian Cancer Syndrome
- Preimplantation Genetic Diagnosis Testing
- Prostate Saturation Biopsy
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders

Durable Medical Equipment (DME)/Prosthetics:

- Augmentative and Alternative Communication (AAC) Devices/ Speech Generating Devices (SGD)
- Electrical Bone Growth Stimulation
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
- Implantable Infusion Pumps
- Lower Limb Prosthesis and Microprocessor Controlled Lower Limb Prosthesis
- Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
- Pneumatic Compression Devices for Lymphedema
- Prosthetics: Electronic or externally powered and select other prosthetics- (myoelectric-UE)
- Standing Frame
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Ultrasound Bone Growth Stimulation
- Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)

Gender Affirming Surgery

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
  - Donor Leukocyte Infusion

  - Intrathecal treatment of Spinal Muscular Atrophy (SMA)
  - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
  - (CAR) T-cell immunotherapy treatment including but not limited to:
    - Axicabtagene ciloleucel (Yescarta™)
    - Tisagenlecleucel (Kymriah™)
    - Brexucabtagene Autoleucel (Tecartus)
- Gene Therapy Treatment & Replacement.

Mental Health/Substance Abuse (MHSA):
Precertification Required

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

**** Please check benefits for any exclusions, or specific precertification requirements***

Other Outpatient and Surgical Services:

- Air Ambulance (excludes 911 initiated emergency transport)
- Abdominoplasty, Panniculectomy, Diastasis Recti Repair
- Ablative Techniques as a Treatment for Barrett's Esophagus
- Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Axial Lumbar Interbody Fusion
- Balloon and Self-Expanding Absorptive Sinus Ostial Dilation
- Blepharoplasty
- Bone-Anchored and Bone Conduction Hearing Aids
- Brachioplasty
- Breast Procedures; including Reconstructive Surgery, Implants and other Breast Procedures
- Bronchial Thermoplasty for Treatment of Asthma
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cervical and Thoracic Discography
- Chin Implant, Mentoplasty, Osteoplasty Mandible
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- Corneal Collagen Cross-Linking
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation pacing systems

- Electric Tumor Treatment Field (TTF)
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
- Functional Endoscopic Sinus Surgery
- Immunoprophylaxis for respiratory syncytial virus (RSV)/ Synagis (palivizumab)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implantable or Wearable Cardioverter-Defibrillator
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Implanted Devices for Spinal Stenosis
- Insertion/injection of prosthetic material collagen implants
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Leadless Pacemaker
- Liposuction/lipectomy
- Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- Lumbar Discoraphy
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Mastectomy for Gynecomastia
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- Mechanical Embolectomy for Treatment of Acute Stroke
- Meniscal Allograft Transplantation of the Knee
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous and Endoscopic Spinal Surgery
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- Perirectal Spacers for Use During Prostate Radiotherapy (Space Oar)
- Photocoagulation of Macular Drusen
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing
- Procedures Performed on Male or Female Genitalia
- Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
- Procedures Performed on the Trunk and Groin
- Reduction Mammaplasty

- Repair of pectus excavatum/carinatum
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Skin-Related Procedures
- Subtalar Arthroereisis
- Surgical and Ablative Treatments for Chronic Headaches
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Surgical Treatment of Obstructive Sleep Apnea and Snoring
- Therapeutic Apheresis
- Total Ankle Replacement
- Transanal Hemorrhoidal Dearterialization (THD)
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation (Radiofrequency and Cryoablation)
- Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- Transcatheter Heart Valve Procedures
- Transcatheter Uterine Artery Embolization
- Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia
- Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
- Treatment of Hyperhidrosis
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Treatment of Varicose Veins (Lower Extremities)
- Treatments for Urinary Incontinence
- Vagus Nerve Stimulation
- Venous Angioplasty with or without Stent Placement/ Venous Stenting
- Viscocanalostomy and Canaloplasty

Out-of-Network Referrals:
Out-of-Network Services for consideration of payment at Network benefit level (may be authorized, based on network availability and/or Medical Necessity.)

Radiation Therapy/ Radiology Services

- Intensity Modulated Radiation Therapy (IMRT)
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
- Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver
- Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule Precertification

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

(1) Procedures, equipment, and/or specialty infusion drugs which have medically necessary criteria determined by Corporate Medical Policy or Adopted Clinical Guidelines.

Who is Responsible for Precertification?

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with the Claims Administrator to ask for a Precertification. However, You may request a Precertification or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Anthem Blue Cross Blue Shield (GA); and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company.	Provider	• The Provider must get Precertification when required
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.

Provider Network Status	Responsibility to Get Precertification	Comments
BlueCard Provider outside the service areas of the states listed in the column above and BlueCard Providers in other states not listed	Member (Except for Inpatient Admissions)	• Member must get Precertification when required. (Call Member Services.) Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. • BlueCard Providers must obtain precertification for all Inpatient Admissions.
NOTE: For an Emergency Care admission, precertification is not required. However, You, Your authorized representative or Doctor must tell the Claims Administrator no later than 2 business days after admission or as soon as possible within a reasonable period of time.		

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

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

If You are not satisfied with the Plan's decision under this section of Your benefits, please refer to the **Your Right To Appeal** section to see what rights may be available to You.

Decision and Notice Requirements

The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on Federal laws. You may call the phone number on the back of Your Identification Card for more details.

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

If more information is needed to make a decision, the Claims Administrator will tell the requesting Provider of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required timeframe, the Claims Administrator will make a decision based upon the information it has.

The Claims Administrator will notify You and Your Provider of its decision as required by Federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

From time to time certain medical management processes (including utilization management, case management, and disease management) may be waived, enhanced, changed or ended. An alternate benefit may be offered

if in the Plan's sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying Providers may be selected to take part in a program or a provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

Just because a process, Provider or Claim is exempted from the standards which otherwise would apply, it does not mean that this will occur in the future, or will do so in the future for any other Provider, claim or Member. The Plan may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by contacting the Member Services number on the back of Your Identification Card.

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

Health Plan Individual Case Management

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

The Claims Administrator's Case Management programs are confidential and voluntary and are made available at no extra cost to You. These programs are provided by, or on behalf of and at the request of, Your health Plan case management staff. These Case Management programs are separate from any Covered Services You are receiving.

If You meet program criteria and agree to take part, the Claims Administrator will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Doctor(s), and other Providers.

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet Your needs. This may include giving You information about external agencies and community-based programs and services.

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. The Claims Administrator's will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if in the Claims Administrator's discretion, the alternate or extended benefit is in the best interest of You and the Plan and You or Your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify You or Your authorized representative in writing.

BENEFITS

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details.

All Covered Services must be Medically Necessary, whether provided through Network or Out-of-Network Providers.

Ambulance Service

Medically Necessary Ambulance Services are a Covered Service when:

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

And one or more of the following criteria are met:

- For ground ambulance, You are taken:
  - From Your home, the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital;
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, You are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital;
  - Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ground Ambulance Services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If You do not use the air ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's Maximum Allowed Amount.

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

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

Ambulance Services are not covered when another type of transportation can be used without endangering Your health. Ambulance services for Your convenience or the convenience of Your family or 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;
- A morgue or funeral home.

Important Notes on Air Ambulance Benefits

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

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

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

Assistant Surgery
Services rendered by an assistant surgeon are covered based on Medical Necessity.

Behavioral Health Care and Substance Abuse Treatment
See the **Schedule of Benefits** for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or Outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Book.

Covered Services include the following:

ABA Therapy – Medically Necessary applied behavioral analysis services.

- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - Observation and assessment by a psychiatrist weekly or more often,
  - Rehabilitation and therapy.
- **Online Visits** when available in Your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits 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 doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

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

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse Specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when they have to be covered by law.

Breast Cancer Care
Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Member. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Member.

Breast Reconstructive Surgery

Covered Services are provided following a mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

Cardiac Rehabilitation

Covered Services are provided as outlined in the **Schedule of Benefits**.

Clinical Trials

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

Benefits are limited to the following trials:

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

Your Plan may require You to use a Network Provider to maximize Your benefits.

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

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

Your Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services:

1. The Experimental/Investigative item, device, or service, itself; or
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; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Consultation Services
Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

Staff consultations required by Hospital rules are excluded. Referrals, the transfer of a patient from one Physician to another for treatment, are not consultations under this Plan.

Dental Services– (Requires Medical Necessity)
Related to Accidental Injury
Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Member's condition. Injury as a result of chewing or biting is not considered an Accidental Injury except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

Treatment must be completed within the timeframe shown in the **Schedule of Benefits**.

Diabetes
Equipment and Outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for Outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Dialysis Treatment
The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Member has not applied for eligible coverage available through Medicare.

Durable Medical Equipment
This Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Member's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or Injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the Member's physical disorder.

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Emergency Services
Life-threatening Medical Emergency or Serious Accidental Injury

Coverage is provided for Hospital Emergency Room or freestanding emergency Facility care including a medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital, or freestanding emergency Facility including ancillary services routinely available to the emergency department or

freestanding emergency Facility to evaluate an Emergency Medical Condition; and within the capabilities of the staff and Facilities available at the Hospital, or freestanding emergency Facility such further medical or behavioral health examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan.

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

Medically Necessary services will be covered whether You get care from a Network or Out-of-Network Provider. Emergency Care You get from an Out-of-Network Provider will be covered as a Network service and will not require Precertification. The Out-of-Network Provider can only charge You any applicable Deductible, Coinsurance, and/or Copayment and cannot bill You for the difference between the Maximum Allowed Amount and their billed charges until Your condition is stable as described in the Consolidated Appropriations Act of 2021 Notice at the front of this Benefit Book. Your cost shares will be based on the Maximum Allowed Amount and will be applied to Your Network Deductible and Network Out-of-Pocket Limit.

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

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

For non-Emergency Care please use the closest Network Urgent Care Center and/or Your Primary Care Physician for services.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the **Schedule of Benefits**.

Gender Affirming Surgery

This Plan provides benefits for many of the charges for Gender Affirming Surgery for Members diagnosed with Gender Dysphoria. Gender Affirming Surgery must be approved by us for the type of surgery requested and must be authorized prior to being performed. Charges for services that are not authorized for the Gender Affirming Surgery requested will not be considered Covered Services. Some conditions apply, and all services must be authorized by us as outlined in the Health Care Management - Precertification section.

Gene Therapy Services

Your Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification and FDA approval. See **Health Care Management** - **Precertification** for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is a Network Provider for other services it may not be an approved Provider for certain 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:

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

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

- Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:
- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

Habilitative Services

Benefits also include habilitative 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 impairments in a variety of Inpatient and/or outpatient settings.

Home Health Care Services

Home Health Care provides a program for the Member's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Member's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Member must be essentially confined at home.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Member.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Member to understand the emotional, social, and environmental factors resulting from or affecting the Member's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

- Food, housing, homemaker services, sitters, home-delivered meals.
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care Plan as described.
- Services of a person who ordinarily resides in the Member's home or is a member of the family of either the Member or Member's Spouse.
- Any services for any period during which the Member is not under the continuing care of a Physician.
- Convalescent or Custodial Care where the Member has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Member.
- Any services or supplies not specifically listed as Covered Services.
- Routine care and/or examination of a newborn child.

- Dietician services.
- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.

Hospice Care Services

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

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate Plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes.
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies.

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 the Claims Administrator upon request.

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

Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

Network

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Services and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

- Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **Schedule of Benefits** section.

Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

Human Organ and Tissue Transplant Services

Notification

To maximize Your benefits, You need to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider that we have chosen as a Centers of Medical Excellence for Transplant Provider and/or a Provider designated as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are Network Transplant Providers.

Centers of Medical Excellence (CME) Transplant Providers

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

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

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

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

Contact the Member Services telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or benefit book exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Member.

Covered Transplant Benefit Period

At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Solid Organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a Covered Bone Marrow/Stem Cell Transplant Procedure and lasts for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

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

Prior Approval and Precertification

In order to maximize Your benefits, the Claims Administrator strongly encourages You to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any

clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Member Services telephone number on the back of Your Identification Card **and ask for the transplant coordinator.** Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Claims

Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the Facility where Your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the Facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Licensed Speech Therapist Services

Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits**. Developmental speech therapy is **not** covered under the speech therapy benefit.

Maternity Care and Reproductive Health Services

Covered Services are provided for Network Maternity Care subject to the benefit stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. See "Changing Coverage (Adding a Dependent)" to add a newborn to Your coverage.

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96-hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Member's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Member will have access to two post-discharge follow-up visits within the 48- or 96-hour period. These visits may be provided either in the Physician's office or in the Member's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Member's attending Physician.

Abortion (Therapeutic or Elective)

Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape. Your Plan also provides benefits for an elective (voluntary) abortion, which is an abortion performed for reasons other than those described above. Coverage and benefits are provided to the extent permitted under applicable law, which may include laws of the state in which the medical services are provided as well as laws of the state in which the covered Member resides.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine 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.

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

Nutritional Counseling
Nutritional counseling related to the medical management of disease state as stated in the **Schedule of Benefits**.

Obesity
Prescription Drugs and any other treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan.

Online Visits(Telehealth and/or Telephonic)
When available in Your area, Your coverage will include online visits (including Telehealth and/or Telephonic) from a LiveHealth Online Provider. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See **Schedule of Benefits** for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. For Behavioral Health and Substance Abuse Online Visits, see the "Behavioral Health Care and Substance Abuse Treatment" section. Non-Covered Services include, but are not limited to communications used for:

- reporting normal lab or other test results;
- office appointment requests;
- billing, insurance coverage or payment questions;
- requests for referrals to Physicians outside of the online care panel;
- benefit precertification; and
- Physician to Physician consultation.

Oral Surgery
Covered Services include only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan and performed within the time frames shown in the **Schedule of Benefits**: after the accident.

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:

- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Other Covered Services
Your Plan provides Covered Services when the following services are Medically Necessary:

- Chemotherapy and radioisotope, radiation and nuclear medicine therapy;
- Diagnostic x-ray and laboratory procedures;
- Dressings, splints, casts when provided by a Physician;
- Oxygen, blood and components, and administration;
- Pacemakers and electrodes;
- Use of operating and treatment rooms and equipment.

Out-of-Network Freestanding Ambulatory Facility

Any services rendered or supplies provided while You are a patient or receiving services at or from an Out- of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

Out-of-Network Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the **Schedule of Benefits** section.

Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

Outpatient Surgery

Network Hospital Outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under "Hospital Services".

Physical Therapy, Occupational Therapy, Manipulation Therapy

Services by a Physician, a registered physical therapist (R.P.T.) a licensed occupational therapist (O.T.), licensed acupuncturist, or a licensed chiropractor (D.C.) as outlined in the **Schedule of Benefits**. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider.

Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements. Consultations between Your Primary Care Physician and a Specialty Care Physician are included, when approved by Anthem.

Preventive Services

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

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

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    a. Breast cancer;
    b. Cervical cancer;
    c. Colorectal cancer;
    d. High Blood Pressure;
    e. Type 2 Diabetes Mellitus;
    f. Cholesterol;
    g. Child and Adult Obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive Services and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Preventive Services and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
   a. Women's contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
   b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
   c. Gestational diabetes screening.
5. HPV (Human Papillomavirus) Vaccine
6. Pre exposure prophylaxis (PEP)

You may call Member Services using the number on Your Identification Card for additional information about these services or view the Federal government's web sites, http://www.ahrq.gov/clinic/uspstfix.htm; http://www.healthcare.gov/center/regulations/prevention.html; or http://www.cdc.gov/vaccines/recs/acip/.

Covered Services also include the following services required by State law:

- Routine screening mammograms. The total benefit for a screening mammography under this Plan, regardless of the number of claims submitted by Providers, will not exceed the allowed amount per Federal or State law for a screening mammography. If a Provider, Hospital, or other health care Facility provides a service that is a component of the screening mammography and submits a separate claim for that component, a separate payment shall be made to the Provider, Hospital, or other health care Facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. The benefit paid for mammography constitutes full payment under this Certificate. No Provider, Hospital, or other health care Facility shall seek or receive compensation in excess of the payment made that corresponds to the ratio paid by Medicare in Ohio.
- Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test).
- Child health supervision services from the moment of birth until age nine. Child health supervision services mean periodic review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, or, in the case of hearing screening, by an individual acting in accordance with Ohio law. Periodic review means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries; electrical or magnetic continence aids (either anal or urethral); implants for cosmetic purposes except for reconstruction following a mastectomy.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, Injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

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

Retail Health Clinic

Retail Health Clinics include local grocery and Pharmacy retailers who provide a walk-in clinic service. Benefits are provided for Covered Services received at a Retail Health Clinic.

Skilled Nursing Facility Care

Benefits are provided as outlined in the **Schedule of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- A favorable prognosis;
- A reasonably predictable recovery time; and
- Services and/or Facilities less intense than those of the acute general Hospital, but greater than those normally available at the Member's residence.

Covered Services include:

- Semiprivate or ward room charges including general nursing service, meals, and special diets. If a Member stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- Use of special care rooms;
- Pathology and radiology;
- Physical or speech therapy;
- Oxygen and other gas therapy;
- Drugs and solutions used while a patient; or
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:

- A Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- No specific medical conditions exist that require care in a Skilled Nursing Facility, or
- The care rendered is for other than Skilled Convalescent Care.

Surgical Care

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

Telemedicine (Also referred to as Telehealth and Telephonic)

Covered Services includes telemedicine services provided to You through synchronous or asynchronous information and communication technology by a Provider, within the Provider's scope of practice, who is in a different location from where You are located. If You have any questions about this coverage, or receive a bill please contact Member Services at the number on the back of Your Identification Card.

Treatment of Accidental Injury in a Physician's Office

All Outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Member's Physician's office benefit and are subject to Deductible and Coinsurance requirements.

LIMITATIONS AND EXCLUSIONS

1. **Admissions for Non-Inpatient Services -** Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
2. **Administrative Charges -** Charges for any of the following:
   a. Failure to keep a scheduled visit;
   b. Completion of claim forms or medical records or reports unless otherwise required by law;
   c. For Physician or Hospital's stand-by services;
   d. For holiday or overtime rates.
   e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
   f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
3. **Allergy Services -** Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
4. **Alternative Therapies –** Hypnotherapy, acupuncture and acupuncture therapy. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris. This exclusion also applies to recreational, or educational sleep therapy or other forms of self-care or nonmedical self-help training and any related diagnostic testing.
5. **Before Coverage Begins / After Coverage Ends -** Services rendered or supplies provided before coverage begins, i.e., before a Member's Effective Date, or after coverage ends.
6. **Biomicroscopy -** Biomicroscopy, field charting or aniseikonic investigation.
7. **Certain Providers -** Service You get from Providers that are not licensed by law to provide Covered Services as defined in this Book and unless otherwise specified in the **Benefits** section. Examples of non-covered Providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
8. **Comfort and Convenience Items -** Personal comfort items such as those that are furnished primarily for Your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
9. **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.
10. **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 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 and surgery to correct birth defects and birth abnormalities.
11. **Court-Ordered Services -** Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.

12. **Crime and Incarceration -** Injuries received while committing a crime as well as care required while incarcerated in a Federal, State or Local penal institution or required while in custody of Federal, State or Local law enforcement authorities, unless otherwise required by law or regulation. This Exclusion does not apply if Your involvement in the crime was solely the result of a medical or mental condition, or where You were the victim of a crime, including domestic violence.
13. **Custodial Care and Rest Care -** Custodial care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain.
14. **Daily Room Charges -** Daily room charges while the Plan is paying for an Intensive care, cardiac care, or other special care unit.
15. **Dental Care -** Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Book.
16. **Developmental Speech Therapy -** Speech therapy for remedial or educational purposes or for initial development of natural speech. This would apply to children who have not established a natural speech pattern for reasons that do not relate to a congenital defect. In these cases, speech therapy would be considered educational in nature and not eligible for coverage. Speech therapy would not meet coverage criteria for the following conditions: chronic voice strain, congenital deafness, delayed speech, developmental or learning disorders, environmental or cultural speech habits, hoarseness, infantile articulation, lisping, mental retardation, resonance, stuttering, and voice defects of pitch, loudness, and quality.
17. **Educational Services -** Educational services for remedial education including evaluation or treatment of learning impairments, minimal brain dysfunctions, learning disorders, behavioral training, and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Plan provides for neurological disorders and applied behavioral analysis), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning impairments, behavioral problems, and mental and intellectual impairment Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
18. **Excessive Expenses -** Expenses in excess of the Plan's Maximum Allowed Amount.
19. **Employer or Association Medical / Dental Department -** Received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group.
20. **Experimental / Investigational Services -** Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigative for the diagnosis for which the Member is being treated. An Experimental or Investigative service is not made eligible for coverage by the fact that other treatment is considered by a Member's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
21. **Family Members -** Services rendered by a Provider who is a close relative or member of Your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.
22. **Foot Care -** Foot care only to improve comfort or appearance, routine care of corns, calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Members with impaired circulation to the lower extremities.
23. **Free Services -** Services and supplies for which You have no legal obligation to pay, or for which no charge has been made or would be made if You had no health insurance coverage.

24. **Government Programs -** Treatment where payment is made by any local, State, or Federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a Member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
25. **Health Spa -** Expenses incurred at a health spa or similar Facility.
26. **Hearing aids**, hearing devices or examinations for prescribing or fitting them.
27. **Ineligible Hospital -** Any services rendered or supplies provided while You are confined in an Ineligible Hospital.
28. **Ineligible Provider -** Any services rendered or supplies provided while You are a patient or receive services at or from an Ineligible Provider.
29. **Infant Formula** - regardless of Medical Necessity.
30. **Infertility Services -** For artificial insemination, fertilization (such as in vitro or GIFT) or procedures and testing related to fertilization; Infertility drugs and related services including the diagnosis of Infertility.
31. **Inpatient Rehabilitation Programs -** Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation Facility, when the Member is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
    a. the treatment is for maintenance therapy; or
    b. the Member has no restorative potential; or
    c. the treatment is for congenital learning or neurological impairment/disorder; or
    d. the treatment is for communication training, educational training or vocational training.
32. **International Services -** Non-emergency treatment of chronic illnesses received outside the United States performed without preauthorization. See the information on the Blue Cross Blue Shield Global Basic Core® International Coverage program in this Benefit Book for further details.
33. **Maintenance Care -** Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, Injury or condition which is resolved or stable.
34. **Marital Counseling -** Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
35. **Never Events –** The Plan will not pay for errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care Facility. The Provider will be expected to absorb such costs. This Exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.
36. **Non-Approved Facility** - Services from a Provider that does not meet the definition of Facility.
37. **Non-Covered Services -** Any item, service, supply or care not specifically listed as a Covered Service in this Benefit Book.
38. **Not Medically Necessary Services -** Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet The Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
39. **Obesity Services –** Services for weight reduction programs, services and supplies. Weight loss programs including but not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss).
40. **Over the Counter Drug Equivalents -** Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply may not be covered even written as a Prescription. This Exclusion does not apply to over-the-counter products that the Plan must cover as a "Preventive Care" benefit under Federal law with a Prescription.
41. **Prescription Drug Service Exclusions** – Refer to the Prescription Drug Exclusions section.
42. **Private Duty Nursing –** For Private Duty Nursing services except when provided through the "Home Care" benefit.
43. **Private Rooms -** Private room, except as specified as Covered Services.

44. **Research Screenings –** For examinations related to research screenings, unless required by law.
45. **Residential Accommodations -** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:
    a. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    b. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care Facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar Facility or institution.
    c. Services or care provided or billed by a school, Custodial Care center for the developmentally impaired, or outward-bound programs, even if psychotherapy is included.
46. **Reversal of Elective Sterilization -** Services related to or performed in conjunction with reverse elective sterilization.
47. **Routine Examinations -** Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms illness or Injury except those which may be specifically listed as covered in this Benefit Book.
48. **Safe Surroundings -** Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
49. **Sclerotherapy -** Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
50. **Services Not Specified as Covered.** No Benefits are available for services that are not specifically described as Covered Services in this Benefit Book. This exclusion applies even if Your Physician orders the service.
51. **Sexual Dysfunction -** Medical/ surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction) regardless of origin or cause. This exclusion also includes penile prostheses or Implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
52. **Shoes -** Shoe inserts, (except when prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
53. **Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary -** Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to:
    a. Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards;
    b. Household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs;
    c. The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment;
    d. Water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers;
    e. Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to a Member's house or place of business and adjustments made to vehicles;
    f. Air conditioners, humidifiers, dehumidifiers, or purifiers;
    g. Rental or purchase of equipment if You are in a Facility which provides such equipment;
    h. Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications; and,

i. Other items of equipment that the Claims Administrator determines do not meet the listed criteria.

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

54. Services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law.
55. **Temporomandibular Joint Disease** – Treatment for Temporomandibular Joint Disease (TMJ) including surgical and diagnostic services. This exclusion also applies to splints used in the treatment of TMJ.
56. **Therapy Services -** Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Book. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.
57. **Transplant Services** - The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
    a. Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
    b. Transportation, travel or lodging expenses for non-donor family Members;
    c. Donation related services or supplies, including search, associated with organ acquisition and procurement;
    d. Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered; any transplant not specifically listed as covered.
    e. Any transplant not specifically listed as covered.
58. **Transportation -** Transportation provided by other than a state licensed professional ambulance service, and Ambulance Services that are not Medically Necessary. Transportation to another area for medical care is also excluded except as stated as covered under the “Ambulance Service” section. Ambulance transportation from the Hospital to the home is not covered.
59. **Travel Costs and Mileage -** For mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer.
60. **Thermograms -** Thermograms and thermography.
61. **Vein Treatment -** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
62. **Vision Care -** Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Analysis of vision or the testing of its acuity (refraction) except as otherwise indicated in this Benefit Book. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes. Routine Screening for adults is provided every 24 months.
63. **Vision Surgeries -** Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
64. **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.
65. **Waived Fees -** Any portion of a Provider's fee or charge which is ordinarily due from a Member but which has been waived. If a Provider routinely waives (does not require the Member to pay) a Deductible or

Out-of-Pocket amount, the Claims Administrator will calculate the actual Provider fee or charge the fee or charge by the amount waived.

66. **War / Military Duty -** Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military Facilities except as required by law.
67. **Worker's Compensation -** Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. If Workers' Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.

CLAIMS PAYMENT

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield Plan in their area. Therefore, if the BlueCard® PPO Network Hospitals, Physicians and Ancillary Providers are used, claims for their services will generally not have to be filed by the Member. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the Provider requests a claim form to file a claim, a claim form can be obtained by contacting Your local Human Resources Department or by visiting www.anthem.com.

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign Providers from sending Your claims and other personal information to the Claims Administrator.

How to File Claims

Under normal conditions, the Claims Administrator should receive the proper claim form within 90 days, not to exceed 12months after the service was provided. Participating providers are to follow the contractual filing limitations. This section of the Benefit Book describes when to file a benefit claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan.

When You receive Covered Services from a Network Physician or other Network licensed health care Provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the Provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from Your Employer or the Claims Administrator. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Maximum Allowed Amount

General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that You receive. Please see the Inter-Plan Arrangements section for additional information.

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

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

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

Surprise Billing Claims are described in the **Consolidated Appropriations Act of 2021 Notice section at the front of this Benefit* Book. *Please refer to that section for further details.*

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply

claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means Claims Administrator has 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 Physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

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

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

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers.

Except for Surprise Billing Claims, we will calculate the Maximum Allowed Amount for Covered Services You receive from an Out-of-Network Provider using one of the following:

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its' discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third-party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount or if Your claim involves a Surprise Billing Claim.

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

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

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

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

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

The Plan will not provide any reimbursement for Non-Covered Services. You may be responsible for the total amount billed by Your Provider for Non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Benefit Book and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

Authorized Services
In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless Your claim involves a Surprise Billing Claim. Please contact Member Services for Authorized Services information or to request authorization.

Services Performed During Same Session

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. **If services are performed by Out-of-Network Providers,** then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount **with or without a referral or regardless if allowed as an Authorized Service.** Contact the Claims Administrator for more information.

Processing Your Claim

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

Timeliness of Filing − Member Submitted Claims

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 90 days, not to exceed 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Necessary Information

In order to process Your claim, the Claims Administrator may need information from the Provider of the service. As a Member, You agree to authorize the Physician, Hospital, or other Provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

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

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

Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;
- the amount for which You are responsible (if any); and
- general information about Your Appeals rights and information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan 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 the Claims Administrator serves (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. Explained below is 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.

A. Blue Card® Program

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

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

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

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

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

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

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees
Federal or State laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

E. Nonparticipating Providers Outside the Claims Administrator's Service Area

1. **Allowed Amounts and Member Liability Calculation**

   When Covered Services are provided outside of Anthem's Service Area by non-participating Providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable State or Federal law. In these situations, the amount You pay for such services as Deductible, 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 the Plan will make for the Covered Services as set forth in this paragraph. Federal or State law, as applicable, will govern payments for out-of-network Emergency services.

2. **Exceptions**

   In certain situations, the Plan may use other pricing methods, such as billed charges or the pricing the Plan would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Plan make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core ® Program

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

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll-free number is 800-810-2583. Or You can call them collect at 804-673-1177.If You need Inpatient Hospital care, You or someone on Your behalf, should contact the Claims Administrator for preauthorization. Keep in mind, if You need Emergency medical care, go to the nearest Hospital. There is no need to call before You receive care.

Please refer to the **Health Care Management – Precertification** section in this Book 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.

Unauthorized Use of Identification Card

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

forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Assignment

You authorize the Claims Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. The Claims Administrator also reserves the right to make payments directly to You. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by the Claims Administrator will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by any applicable Federal law.

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

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.

Questions About Coverage or Claims

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Member Services Department. Be sure to always give Your Member Identification number.

When asking about a claim, give the following information:

- Identification number;
- Patient's name and address;
- Date of service and type of service received; and
- Provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call the Claims Administrator.

The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor the Claims Administrator is responsible for any Injuries or damages You may suffer due to actions of any Hospital, Physician or other person. In order to process Your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of Your benefits by an Employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of Your new address.

YOUR RIGHT TO APPEAL

The Claims Administrator's Member Services representatives are trained to answer Your questions about Your health benefit Plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Coinsurance and Copayment amounts,
- Specific claims or services You have received,
- Doctors or Hospitals in the Network,
- Referral processes or authorizations,
- Provider directories.

Complaint and Appeal procedures have been established to provide fair, reasonable, and timely solutions to complaints that You may have concerning the Plan. The Plan invites You to share any concerns that You may have over benefit determinations, coverage and eligibility issues, or the quality of care rendered by medical Providers in the Claims Administrator's Networks.

The Complaint Procedure

The Plan wants Your experience to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. In those cases, please contact Member Services by calling the number on the back of Your ID card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim.

Please refer to Your Identification Card for the Claims Administrator's address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Claims Administrator of its' procedures and Your benefit document. You may submit Your complaint by letter or by telephone call. If Your complaint involves issues of Covered Services, You may be asked to sign a release of information form so the Claims Administrator can request records for its' review.

You will be notified of the resolution of Your complaint if a claim or request for benefits is denied in whole or in part. The Claims Administrator will explain why benefits were denied and describe Your rights under the Appeal Procedure. If You are not satisfied with the resolution of Your complaint, You have the right to file an Appeal, which is defined as follows:

Appeal Procedures

As a Member of this Plan You have the right to appeal decisions to deny or limit Your health care benefits. The explanation of why the Plan denied Your claim or request for benefits will describe the steps You should follow to initiate Your appeal and how the appeal process works.

An appeal is a request from You for the Claims Administrator to change a previous determination or to address a concern You have regarding confidentiality or privacy.

Internal Appeals

An initial determination by the Claims Administrator can be appealed for internal review. The Plan will advise You of Your rights to appeal to the next level if a denial occurs after an initial determination.

You have the right to designate a representative (e.g. Your Physician) to file appeals with the Claims Administrator on Your behalf and to represent You in any level of the appeals process. If a representative is seeking an appeal on Your behalf, the Claims Administrator must obtain a signed Designation of Representation (DOR) form from You. The appeal process will not begin until the Claims Administrator has received the properly completed DOR form except that if a Physician requests expedited review of an appeal on Your behalf, the Physician will be deemed to be Your designee for the limited purpose of filing for expedited review of the appeal without receipt of a signed form. The Claims Administrator will forward a Designation of Representation form to You for completion in all other situations.

The Claims Administrator will accept oral or written comments, documents or other information relating to an appeal from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal. If, after the Claims Administrator's determination that You are appealing, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal(s) decision(s) on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the appeal procedures outlined under this section the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

To obtain information on the Claims Administrator's appeal procedures or to file an oral appeal please call the toll-free Member Services number listed on the back of Your Plan Identification Card or the number provided for appeals on any written notice of an adverse decision that You receive from the Claims Administrator.

The Claims Administrator will also accept appeals filed in writing. If You wish to file Your appeal in writing, You must mail it to: Anthem Blue Cross and Blue Shield, P.O. Box 105568, Atlanta, GA 30348, or to the address provided for filing an appeal on any written notice of an adverse decision that You receive from the Claims Administrator.

Appeals are reviewed by persons who did not make the initial determination and who are not the subordinates of the initial reviewer. If a clinical issue is involved, the Claims Administrator will use a clinical peer for this review. A clinical peer is a Physician or Provider who has the same license as the Provider who will perform or has performed the service. The clinical peer will review Your medical records and determine if the service is covered by Your benefit document. If the clinical peer determines that the service is covered by Your benefit document the Plan must pay for the service; if the clinical peer determines that the service is not covered the Plan may deny the services.

Standard Appeals

If You are appealing an adverse precertification decision other than a retrospective post-claim review decision (i.e., an adverse prospective, concurrent or retrospective pre-claim review decision) or the denial of any prior approval required by the Plan, the Claims Administrator will provide You with a written response indicating the Claims Administrator's decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days of the date the Claims Administrator receives Your appeal request. If more information is needed to make a decision on Your Appeal, the Claims Administrator will send a written request for the information after receipt of the Appeal. No extensions of time for additional information may be taken on these Appeals without the permission of the Member. Therefore, the Claims Administrator will make a decision based upon the available information if the additional information requested is not received.

If You are appealing any other type of adverse decision (including retrospective post-claim review decisions) and sufficient information is available to decide the Appeal, the Claims Administrator will provide You with a written response indicating its' decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days from receipt of the Appeal request. If more information is needed to make a decision on Your Appeal, the Claims Administrator shall send a written request for the information after receipt of the Appeal. If the additional information requested is not received within 45 calendar days of the Appeal request, the Claims Administrator shall conduct its review based upon the available information.

Expedited Appeals

An expedited appeal may be initiated orally, in writing, or by other reasonable means available to You or Your Provider. Given the urgent nature of an expedited appeal, You are encouraged to request an expedited appeal orally. An expedited appeal is available only if the medical care for which coverage is being denied has not yet been rendered. The Claims Administrator will complete expedited review of an appeal as soon as possible given the medical exigencies but no later than seventy-two hours (72 hours) after the Claims Administrator's receipt of the request and will communicate the Claims Administrator's decision by telephone to Your attending Physician or the ordering Provider. The Claims Administrator will also provide written notice of the Claims Administrator's determination to You, Your attending Physician or ordering Provider, and the Facility rendering the service.

You may request an expedited review for:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-Urgent Care determinations:
  1. Could seriously jeopardize Your life or health or Your ability to regain maximum function, or,
  2. In the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- Except as provided above, a claim involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of Your medical condition determines is a claim involving Urgent Care.

Exhaustion of Internal Appeals Process
The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

- The Claims Administrator agrees to waive the exhaustion requirement; or
- You did not receive a written decision of the Claims Administrator's internal appeal within the required time frame; or
- The Claims Administrator failed to meet all requirements of the internal appeal process unless the failure:
  1. Was de minimis (minor);
  2. Does not cause or is not likely to cause prejudice or harm to You;
  3. Was for good cause and beyond the Claims Administrator's control;
  4. Is not reflective of a pattern or practice of non-compliance: or
  5. An expedited external review is sought simultaneously with an expedited internal review.

External Review
Definitions as used in the External Review section include the following:

"Adverse benefit determination" means a decision by a health Plan issuer:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
  1. A determination that the health care service does not meet the health Plan issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
  2. A determination of an individual's eligibility for individual health insurance coverage, including coverage offered to individuals through a non-Employer group, to participate in a Plan or health insurance coverage;
  3. A determination that a health care service is not a covered benefit;
  4. The imposition of an exclusion, including exclusions source of Injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-Employer group;
- To rescind coverage on a health benefit Plan.

"Authorized representative" means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family Member or a treating health care professional, but only when the covered person is unable to provide consent.

“Covered person” means a subscriber, enrollee, Member, or individual covered by a health benefit Plan. “Covered person” does include the covered person’s authorized representative with regard to an internal appeal or external review.

“Covered benefits” or **“benefits”** means those health care services to which a covered person is entitled under the terms of a health benefit Plan.

“Final adverse benefit determination” means an adverse benefit determination that is upheld at the completion of a health Plan issuer’s internal appeals process.

“Health benefit Plan” means a benefit Plan offered by an Employer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

“Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, Injury, or disease.

“Health Plan issuer” means an entity subject to the insurance laws and rules of this State, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit Plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self- funded multiple Employer welfare arrangement, or a non-Federal, government health Plan. “Health Plan issuer” includes a third-party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit Plan are subject to the insurance laws and rules of this State or subject to the jurisdiction of the superintendent. The “Health Plan issuer” is also called the Claims Administrator in this Benefit Book.

“Independent review organization” means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.

“Rescission” or **“to rescind”** means a cancellation or discontinuance of coverage that has a retroactive effect. “Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

“Stabilize” means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.
- In the case of a woman having contractions, “stabilize” means such medical treatment as may be necessary to deliver, including the placenta.

“Superintendent” means the superintendent of insurance.

Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all health Plan issuers must provide a process that allows a person covered under a health benefit Plan or a person applying for health benefit Plan coverage to request an independent external review of an adverse benefit determination. This is a summary of that external review process. An adverse benefit determination is a decision by the Plan to deny benefits because services are not covered, are excluded, or limited under the Plan, or the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of medical necessity, appropriateness, health care setting, or level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit Plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health Plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

External Review by an IRO - A covered person is entitled to an external review by an IRO in the following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information.
- The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person's health benefit Plan, and the treating Physician certifies at least one of the following:
  - Standard health care services have not been effective in improving the condition of the covered person.
  - Standard health care services are not medically appropriate for the covered person.
  - No available standard health care service covered by the Plan is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The covered person's treating Physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.
- The covered person's treating Physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received Emergency services, but has not yet been discharged from a Facility.
- An expedited internal appeal is already in progress for an adverse benefit determination of experimental or investigational treatment and the covered person's treating Physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

Note: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person).

External Review by the Ohio Department of Insurance - A covered person is entitled to an external review by the Department in the either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The adverse benefit determination for an Emergency medical condition indicates that medical condition did not meet the definition of Emergency AND the Claims Administrator's decision has already been upheld through an external review by an IRO.

Request for External Review
Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through the Claims Administrator within 180 days of the date of the notice of final adverse benefit determination issued by the Claims Administrator. All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally; however written confirmation of the request must be submitted to the Claims Administrator no later than five (5) days after the initial request. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete the Claims Administrator will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. The Claims Administrator will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete the Claims Administrator will inform the covered person in writing and specify what information is needed to make the request complete. If the Claims Administrator determines that the adverse benefit determination is not eligible for external review, the Claims Administrator must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by the Claims Administrator and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit Plan and all applicable provisions of the law.

IRO Assignment
When the Claims Administrator initiates an external review by an IRO, the Ohio Department of Insurance web-based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with the Claims Administrator, the covered person, the health care Provider or the health care Facility will not be selected to conduct the review.

IRO Review and Decision
The IRO must consider all documents and information considered by the Claims Administrator in making the adverse benefit determination, any information submitted by the covered person and other information such as; the covered person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit Plan, the most appropriate practice guidelines, clinical review criteria used by the health Plan issuer or its Utilization Review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by the Claims Administrator of a request for a standard review or within 72 hours of receipt by the Claims Administrator of a request for an expedited review. This notice will be sent to the covered person, the Claims Administrator and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards that was used or considered in reaching its decision.

Note: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An external review decision is binding on the Plan except to the extent the Claims Administrator has other remedies available under State law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable State or Federal law. A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to the Claims Administrator.

If You Have Questions About Your Rights or Need Assistance

You may contact the Claims Administrator:

Anthem Blue Cross and Blue Shield
P.O. Box 105568, Atlanta, GA 30348

To contact the Claims Administrator by phone please call the number on back of Your Identification Card

Fax: 1-888-859-3046
E-Mail: Ohio.Appeals@anthem.com

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

File a Consumer Complaint:

http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

Appeal Filing Time Limit

The Plan expects that You will use good faith to file an appeal on a timely basis. However, the Claims Administrator will not review an appeal if it is received after 180 days have passed since the incident leading to Your appeal.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when You have health care coverage under more than one Plan.

- When the Spouse is enrolled in or entitled to a Plan maintained by his/her Employer, coverage for the Spouse under this Plan will be secondary to the coverage provided by the Spouse's Employer's Plan. The Employee or Spouse of Employee will need to provide all information required to administer this provision through the enrollment form or through the COB questionnaire form. Until the Claims Administrator has received all the required documentation, any claims for the Spouse will be denied or returned to the sender.
- This Plan does not cover any secondary claims on prescription drugs. Prescription drugs will only be paid on claims incurred by Members with primary prescription drug coverage through the Northern Buckeye Health Plans, meaning there is no Coordination of Benefits for prescription drug claims, even when another Plan has paid primary.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Benefit Book, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Benefit Book. Plan has the meaning listed in the "Definitions" section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowed expense.

The Allowed expense under COB is generally the higher of the Primary and Secondary Plans' allowed amounts. A Network Provider can bill You for any remaining Coinsurance and Deductible under the higher of the Plans' allowed amounts. This higher allowed amount may be more than the Plan's Maximum Allowed Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: Group and non-group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non-group closed panel Plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government Plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental Plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1 or 2 above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits that the COB provision applies to and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowed expense.

Allowed expense is a health care expense, including Deductibles and Coinsurance, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowed expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowed expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowed expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowed expense, and the Provider may charge up to the higher contracted fee.

The following are non-Allowed expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowed expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowed expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowed expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowed expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowed expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because You have failed to comply with the Plan provisions is not an Allowed expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
6. The amount that is subject to the Primary High-Deductible Health Plan's Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-deductible health Plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

Closed panel Plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel Member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When You are covered by two or more Plans, the rules for determining the order of benefit payments are:

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

1. Except as provided in Paragraph 2 below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical

coverages that are placed over base Plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide Out-of-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

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

Rule 1 - Non-Dependent or Dependent. The Plan that covers You other than as a Dependent, for example as an Employee, Member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers You as a Dependent is the Secondary Plan. However, if You are a Medicare beneficiary and, as a result of Federal law, Medicare is secondary to the Plan covering You as a Dependent and primary to the Plan covering You as other than a Dependent (e.g., a retired Employee), then the order of benefits between the two Plans is reversed so that the Plan covering You as an Employee, Member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering You as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary, where such coverage is engaged. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1 above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     - The Plan covering the Custodial parent;
     - The Plan covering the Spouse of the Custodial parent;
     - The Plan covering the non-custodial parent; and then
     - The Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of items 1 or 2 above will determine the order of benefits as if those individuals were the parents of the child.
4. For a Dependent child who has coverage under either or both parents' Plans and also has his or her own coverage as a Dependent under a Spouses Plan, Rule 5 applies. In the event the Dependent child's coverage under the Spouse's Plan began on the same date as the Dependent child's coverage under either or both parents' Plans, the order of benefits will be determined by applying the birthday rule in item 1 above to the Dependent child's parent(s) and the Dependent's Spouse.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active Employee, that is, an Employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off Employee is the Secondary Plan. The same would hold true if You are a Dependent of an active Employee and You are a Dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other Federal law and are covered under another Plan, the Plan covering You as an Employee, Member, subscriber or retiree or covering You as a Dependent of an Employee, Member, subscriber or retiree is the Primary Plan and the COBRA or other Federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non- Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the Group Health Plan as an Employee or as a retired Employee and is covered under his or her own Plan as an Employee, Member, subscriber or retiree); or (b) as a Dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the Group Health Plan as a Dependent of an Employee, Member or subscriber or retired Employee and is covered under the other Plan as a Dependent of an Employee, Member, subscriber or retiree).

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered You longer is the Primary Plan and the Plan that covered You the shorter period of time is the Secondary Plan.

Rule 6 - If the preceding rules do not determine the order of benefits, the Allowed expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Secondary to Other Coverage

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

Effect on The Benefits of this Plan

When a Member is covered under two or more Plans which together pay more than this Plan's benefits, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is Primary. However, when this Plan is Secondary under the Order of Benefit Determination Rules, benefits payable by this Plan will be reduced by the combined benefits of all other Plans covering You or Your Dependent.

When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If this Plan is secondary, the combined benefits of this Plan and the other Plan will never exceed what would have been provided by this Plan if primary. No benefits will be provided by this Plan when the amount paid by the other Plan is equal to or greater than the amount this Plan would have paid if Primary.

If You are enrolled in two or more Closed panel Plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel Plan, COB will not apply between that Plan and other Closed panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Claims Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Claims Administrator any facts the Claims Administrator need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:

1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

This Plan and Medicare

1. Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.
2. When an Employee becomes entitled to Medicare coverage and is still actively at work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. When a Dependent becomes entitled to Medicare coverage and the Employee is still actively at work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
4. If the Employee is still actively at work, and the Employee and/or Dependent are also enrolled in Medicare, this Plan shall pay as the primary Plan. Medicare will pay as secondary Plan.
5. If the Employee and/or Dependent elect to discontinue health coverage and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

SUBROGATION AND REIMBURSEMENT

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

Definitions

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

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

Subrogation

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

Reimbursement

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

Secondary to Other Coverage

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

Assignment

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

Applicability to All Settlements and Judgments

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

Constructive Trust

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

Lien Rights

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

First-Priority Claim

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

Cooperation

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

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal Injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your Injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- You and Your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal Injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or Recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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

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

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

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

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

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

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

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

Discretion

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

GENERAL INFORMATION

Form or Content of Benefit Book

No agent or Employee of the Claims Administrator is authorized to change the form or content of this Benefit Book. Such changes can be made only through an endorsement authorized and signed by an officer of the Employer.

Circumstances Beyond the Control of the Plan

The Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of Facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, impairment of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical the Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPAA

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

Workers' Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers' Compensation Law. All sums paid or payable by Workers' Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation or equivalent Employer liability or indemnification law.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payer, the benefits under the Plan shall not duplicate any benefits to which Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Medicare

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

Except when Federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to You shall be reimbursed by or on Your behalf to us, to the extent we have made payment for such services. If You do not enroll in Medicare Part B when You are eligible, You may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when You should enroll, and when You are allowed to delay enrollment without penalties.

Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustment to claims.

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

Relationship of Parties (Employer-Member-Claims Administrator)

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

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

Relationship of Parties (Claims Administrator - Network Providers)

The relationship between the Claims Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or Employees of the Claims Administrator, nor is the Claims Administrator, or any Employee of the Claims Administrator, an Employee or agent of Network Providers.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If You have questions regarding such incentives or risk sharing relationships, please contact Your Provider or the Claims Administrator.

Community Insurance Company Note

Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Ohio. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield Plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Book.

Notice

Any notice given under the Plan shall be in writing. The notices shall be sent to: The Employer at its principal place of business; to You at the Subscriber's address as it appears on the records or in care of the Employer.

Modifications or Changes in Coverage

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

Fraud

Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage.

Acts Beyond Reasonable Control (Force Majeure)

Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to the Plan Sponsor's instructions and allow the Plan Sponsor to meet all of the Plan Sponsor's responsibilities under applicable State and Federal law. It is the Plan Sponsor's responsibility to adhere to all applicable State and Federal laws and the Claims Administrator does not assumee any responsibility for compliance.

Conformity with Law

Any provision of the Plan which is in conflict with the applicable Federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.

Clerical Error

Clerical error, whether of the Claims Administrator or the Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

Policies and Procedures

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

Under the terms of the Administrative Service Agreement with Your Employer, the Claims Administrator has the authority, in its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. 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. The Claim's Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to Employer.

Except as required under the Americans with Impairments Act, the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act, the Employer's policies and procedures regarding waiting periods, continuation of coverage or reinstatement of coverage shall apply during the following situations: Employer certified impairment, leave of absence, layoff, reinstatement, hire or rehire. Whether an Employee averages the requisite hours of service to be eligible for coverage shall be determined in accordance with the policies and procedures of the Employer.

Value-Added Programs

The Claims Administrator may offer health or fitness related programs to Members, through which You may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under Your Employer's Group Health Plan and could be discontinued at any time. The Claims Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Waiver

No agent or other person, except an authorized officer of the Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer's Sole Discretion

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

Reservation of Discretionary Authority

The Claims Administrator shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation of the Plan and interpretation of the Benefit Book. This includes, without limitation, the power to construe the Administrative Services Agreement, to determine all questions arising under the Plan, to resolve Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Book of the Plan. A specific limitation or exclusion will override more general benefit language. Anthem has complete discretion to interpret the Benefit Book. The Claims Administrator's determination shall be final and conclusive and may include, without limitation, determination of whether the services, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowed Amount. A Member may utilize all applicable Appeals procedures.

Governmental Health Care Programs

Under Federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group's Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group's Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

Medical Policy and Technology Assessment

The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including the Claims Administrator'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.

Payment Innovation Programs

The Claims Administrator pays Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

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

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

Care Coordination

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

Program Incentives

The Plan may offer incentives from time to time, at its discretion, in order to introduce You to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making You aware of cost-effective benefit options or services, helping You achieve Your best health, and encouraging You to update Member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as the Plan offers the incentives program. The Plan may discontinue an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, it is recommended that You consult Your tax advisor.

Confidentiality and Release of Information

Applicable State and Federal law requires us to undertake efforts to safeguard Your medical information.

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

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

WHEN COVERAGE TERMINATES

Termination of Coverage (Individual)

Employee: The coverage of any Employee covered under this Plan shall terminate at the end of the month or as directed by employer union contracts on the earliest of the following:

- The date the Employee ceases to be eligible for coverage under the Plan; or
- The date of termination of the Plan

Dependent children (attaining age 26): The coverage of Dependent children attaining age 26 covered under the Plan shall terminate at the end of the month on the earliest of the following:

- The last day of the month such individual ceases to meet the definition of Dependent; or
- The date the Employee's coverage terminates under the Plan

Dependent (all others): The coverage of any Dependent (other than identified above) covered under this Plan shall terminate at the end of the month on the earliest of the following:

- The date such individual ceases to be an eligible Dependent under the Plan; or
- On the day a final decree of legal separation, divorce, annulment or dissolution of the marriage is filed, an Employee's Spouse will no longer be eligible for coverage; or
- The date the Employee's coverage terminates under the Plan; or
- Immediately upon notice if:
  - A Covered Person allows a non-Covered Person to use his/her Identification Card to obtain or attempt to obtain benefits; or
  - A Covered Person materially misrepresents a material fact provided to the Group of Claims Administrator or commits fraud or forgery.

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

Unpaid Leave - Continuation of Coverage Policy:

After the Employee has exhausted all paid leave with benefits, and/or is no longer paid by the Employer, the Employee is now on "unpaid leave with benefits." The Plan will provide "unpaid leave with benefits coverage for a maximum of 12 weeks annually. The annual 12-month period is measured forward from the start date of the unpaid leave period. When coverage ends under the Plan following the 12-week period of unpaid leave with benefits, the Employee is eligible for COBRA continuation of coverage.

Notwithstanding the foregoing, the Plan Administrator may, in its sole discretion and on a nondiscriminatory basis, elect to extend coverage during an unpaid leave period beyond the annual 12-week unpaid leave with benefits coverage continuation period in extraordinary circumstances (e.g., including but not limited to pandemics, when necessary or appropriate for administrative purposes, etc.). The Plan does not require unpaid leave to qualify as FMLA leave or military leave in order to be considered an eligible unpaid leave with benefits period. However, if such unpaid leave does qualify as FMLA leave or military leave, such leave period will be subject to any additional requirements set forth in the book that apply to FMLA/military leave periods. Further, any period of unpaid leave with benefits described above will run concurrently with any unpaid FMLA or military extension of coverage.

Continuation of Coverage (Federal Law-COBRA)

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with Federal law. If Your Employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer if You have any questions about Your COBRA rights.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)
COBRA continuation coverage is available when Your group coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, Your Spouse and Your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

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

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

Continuation coverage stops before the end of the maximum continuation period if the Member becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if You become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for Your Spouse and children can last up to 36 months after the date of Medicare entitlement.)

Second Qualifying Event
If Your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, Your Spouse and Dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused Your Spouse or Dependent children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements
In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, Your Employer must notify the company's benefit Plan Administrator within 30 days. You must notify the company's benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator.

Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days. To continue enrollment, You or an eligible family Member must make an election within 60 days of the date Your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies You or Your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage You choose to continue. If the Premium rate changes for active associates, Your monthly Premium will also change. The Premium You must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit Plan Administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

For Employees who are determined, at the time of the qualifying event, to be impaired under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become impaired during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month impairment extension. (This provision also applies if any covered family Member is found to be impaired.) This provision would only apply if the qualified beneficiary provides notice of impairment status within 60 days of the disabling determination. In these cases, the Employer can charge 170% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the impaired at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be impaired, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

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

When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage shall terminate at the end of the month on the earliest of the following:

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

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, or other Group Health Plan coverage options (such as a Spouse's Plan) through what is called a "Special Enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

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

Continuation of Coverage During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the Employee (or his or her Dependents) may have the right to elect to continue health coverage under the Plan. In order to be eligible for coverage during the period that the Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Employee and his or her Dependents can elect to continue coverage under the Plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

Continuation of Coverage Due to Family and Medical Leave (FMLA)

An Employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An Employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the Employee's child.
- The placement of a child with the Employee for the purpose of adoption or foster care.
- To care for a seriously ill Spouse, child or parent.
- A serious health condition rendering the Employee unable to perform his or her job.

If the Employee chooses to continue coverage during the leave, the Employee will be given the same health care benefits that would have been provided if the Employee were working, with the same premium contribution ratio. If the Employee's premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the Employee. It will tell the Employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

The Employee may choose not to retain health coverage during the FMLA leave. If the Employee returns to active working status on or before the expiration of the leave, the Employee is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by this Plan. This Plan's provisions with respect to Deductibles and percentage of payments will apply on the same basis as they did prior to the FMLA leave.

If membership in the Plan is discontinued for non-payment of premium, the Employee's coverage will be restored to the same level of benefits as those the Employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible Dependents. The Employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

Please contact Your Human Resources Department for State specific Family and Medical Leave Act information.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.

DEFINITIONS

Accidental Injury

Bodily Injury sustained by a Member as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Member receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan. This Benefit Book in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Book or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Book and the Administrative Services Agreement, the Administrative Services Agreement shall control.

Ambulance Services

A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

Authorized Service(s)

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Member **may** be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible unless Your claim is a Surprise Billing Claim. For more information, see the **Claims Payment** section as well as the **Consolidated Appropriations Act of 2021 Notice** at the front of this Benefit Book.

Behavioral Health Care

Includes services for Mental Health Disorders, and Substance Abuse. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Benefit Period

One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

Centers of Medical Excellence (CME) Network

A network of health care Facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Members access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Community Insurance Company of Ohio was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance
Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after You meet Your Deductible. For example, if Your Plan lists 80% 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.

Combined Limit
The maximum total of Network and Out-of-Network benefits available for designated health services in the **Schedule of Benefits.**

Complications of Pregnancy
Complications of Pregnancy result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

Congenital Anomaly
A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Consolidated Appropriations Act of 2021
Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the front of this Book for details.

Coordination of Benefits
A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment
A cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the **Schedule of Benefits** for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the Provider when services are rendered.

Cosmetic Surgery
Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Dependent
Any Dependent in a Subscriber's family who meets all the requirements of the Eligibility section of this Benefit Book, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

Covered Services

Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member's Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self- administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self- administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible

The portion of the bill You must pay before Your medical expenses become Covered Services. It usually is applied on a calendar year basis.

Dependent

The Spouse and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Developmentally impaired or physically impaired children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 60 days of attainment of age 26. The Certification of Impairment form will be required periodically by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug Dependent person is assisted, in a Facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug Dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

Durable Medical Equipment

Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease of Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date

The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Member according to its normal procedures.

Elective Surgical Procedure

A surgical procedure that is not considered to be an emergency, and may be delayed by the Member to a later point in time.

Emergency Medical Condition

("Emergency services," "emergency care," or "Medical Emergency") Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Employee (also referred to as a Subscriber and/or Member)

An "Employee" is an individual who meets the eligibility requirements of the Employer Group. This includes working the 15 hours the Employer Group requires for eligibility. This also includes Board Members or other individuals who are required to be covered by State or Federal Law, regardless of hours worked.

An Employee is eligible to enroll in the Plan if 1) You work for a participating Employer Group and You are a member of a group of Employees designated by Your participating Employer Group as eligible to participate, 2) You are a full-time Employee, a Board Member or a Trustee of the Northern Buckeye Health Plan, NW Division of OHI, or 3) Your Employer is contracted by the Trust to provide Chief Administrator support and/or services. NOTE: This Plan does not cover Retirees as an eligibility class or their Dependents.

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.

Experimental/Investigative

Any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

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

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a Service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

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

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

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

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

Facility

A Facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined in this Benefit Book. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

Freestanding Ambulatory Facility

A Facility, with a staff of Physicians, at which surgical procedures are performed on an Outpatient basis-no patients stay overnight. The Facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed and accredited by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Gender Dysphoria

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

Group Health Plan or Plan

An Employee Welfare Benefit Plan established by the Employer, in effect as of the Effective Date.

Home Health Care
Care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency
A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

Hospice
A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed and accredited by the appropriate agency.

Hospice Care Program
A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family Members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed and accredited by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital
An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic Facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care Facility; nursing home; place for rest; Facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or impaired children.

Identification Card
The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

Ineligible Charges
Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

Ineligible Provider
A Provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Member by such a Provider are not eligible for payment.

Infertile or Infertility
The condition of a presumably healthy Member who is unable to conceive or produce conception. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

Initial Enrollee
A person actively employed by the Employer (or one of that person's Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

Injury
Bodily harm from a non-occupational accident.

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

Intensive Care Unit
A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Intensive Outpatient Programs
Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Maternity Care
Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Member under the Plan.

Maximum Allowed Amount
The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the **Claims Payment** section.

Medical Necessity (Medically Necessary)
Procedures, supplies, equipment, or services that we conclude are:

1. Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
2. Given for the diagnosis or direct care and treatment of the medical condition; and
3. Within the standards of good medical practice within the organized medical community; and
4. Not mainly for the convenience of the Doctor or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely given.

The most appropriate procedure, supply, equipment, or service must meet the following requirements:

1. There must be valid scientific evidence to show that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and will have a greater chance of benefit, without a disproportionately greater risk of harm or complications, than other possible treatments; and
2. Generally approved forms of treatment that are less invasive have been tried and did not work or are otherwise unsuitable; and
3. For Hospital stays, acute care as an Inpatient is needed due to the kind of services the patient needs or the severity of the medical condition, and that safe and adequate care cannot be given as an outpatient or in a less intensive medical setting.

The most appropriate procedure, supply, equipment, or service must also be cost-effective compared to other alternative interventions, including no intervention or the same intervention in an alternative setting. Cost-effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of Your illness, Injury or disease, the service is: (1) not more costly than another service or group of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, we will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the Drug could be provided in a Physician's office or the home setting.

Member
Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.

Network Provider
A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or Facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Members through negotiated reimbursement arrangements.

New Hire
A person who is not employed by the Employer on the original Effective Date of the Plan.

Non-Covered Services
Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Out-of-Network Provider
A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

Out-of-Pocket Maximum
The maximum amount of a Member's Coinsurance payments during a given calendar year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

Partial Hospitalization Program
Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Pharmacy
An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

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

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

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

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

Plan Sponsor

The legal entity 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

A Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization

The process applied to certain Prescription Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the Pharmacy & Therapeutics Process.

Provider

A duly licensed person or Facility that provides services within the scope of an applicable license and is a person or Facility that the Plan approves. This includes any Provider rendering services which are required by applicable State law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Book. If You have a question if a Provider is covered, please call the number on the back of Your Identification Card.

Qualified Change in Status

A permitted mid-year election change event recognized under Internal Revenue Code Section 125 and regulations issued thereunder or that constitute a Special Enrollment event under the Health Insurance Portability & Accountability Act of 1996 and regulations issued thereunder. For more information, see the Eligibility Section of this book.

QMCSO, or MCSO – Qualified Medical Child Support Order or Medical Child Support Order

A QMCSO creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit Plan to receive benefits for which the Employee is entitled under the Plan; and includes the name and last known address of the Employee and each such child, a reasonable description of the type of coverage to be provided by the Plan, the period for which coverage must be provided and each Plan to which the order applies.

A MCSO is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a Group Health Plan Member or requires health benefit coverage of such child in such Plan, and is ordered under State domestic relations law; or
- enforces a State law relating to medical child support payment with respect to a Group Health Plan.

Residential Treatment Center / Facility

A Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24-hour availability;
- A staff with one or more Doctors available at all times.
- Residential treatment takes place in a structured Facility-based setting.
- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

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

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

Retail Health Clinic
A Facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Semiprivate Room
A Hospital room which contains two or more beds.

Skilled Convalescent Care
Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient’s home or in a nursing home not certified as a Skilled Nursing Facility.

Skilled Nursing Facility
An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the by the Claims Administrator.

Special Enrollment
An enrollment which takes place during the 60-day period following the date of the event which triggers the Special Enrollment period. The Plan permits a Special Enrollment period for an Employee (or a Dependent), who is eligible for coverage, but not enrolled, to enroll if the Employee (or Dependent) had other coverage and loses it, or if a person becomes a Dependent of the Employee through marriage, birth, adoption or Placement for Adoption.

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.

Spouse
For the purpose of this Plan, a Spouse is defined as shown in the Eligibility section of this Benefit Book.

Surprise Billing Claim
Please refer to the Consolidated Appropriations Act of 2021 Notice section at the front of this Benefit Book for details.

Telehealth
Consultations with Your physician (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet).

Telephonic
Consultations with Your physician (PCP/Specialist) using audio only (telephone).

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

Transplant Providers

Network Transplant Provider - A Provider that has been designated as a “Centers of Medical Excellence” for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a “Centers of Medical Excellence” for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

Urgent Care

Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, procedures, and/or Facilities.

You and Your

Refer to the Subscriber, Member and each Covered Dependent.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (Ob-Gyn) Care

You do not need Prior Authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or following a pre-approved treatment Plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to the Claims Administrator's website, www.anthem.com.

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

Group Health Plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider (e.g., Your Physician, nurse midwife, or Physician Assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or Facilities, or to reduce Your out-of-pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

Also, under Federal law, Plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

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

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

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

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the **Schedule of Benefits**.

If You would like more information on WHCRA benefits, call Your Plan Administrator.

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

If You or Your Spouse is required, due to a QMCSO, to provide coverage for Your child(ren), You may ask Your Employer or Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and Substance Abuse benefits with day/visit limits on medical/surgical benefits. In general, Group Health Plans offering mental health and Substance Abuse benefits cannot set day/visit limits on mental health or Substance Abuse benefits that are lower than any such day/visit limits for medical and

surgical benefits. A Plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and Substance Abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment / Coinsurance and out-of-pocket expenses on mental health and Substance Abuse benefits that is more restrictive than Deductibles, Copayment/Coinsurance and out-of-pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.

Special Enrollment Notice

If You are declining enrollment for Yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll Yourself or Your Dependents in this Plan, if You or Your Dependents lose eligibility for that other coverage (or if the Employer stops contributing towards Your or Your Dependents' other coverage). However, You must request enrollment within 60 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 60 days after the marriage, birth, adoption, or placement for adoption.

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

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

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

To request Special Enrollment or obtain more information, call the Member Services telephone number on Your Identification Card, or contact Your Plan Administrator.

Consolidated Appropriations Act of 2021

Please refer to the Consolidated Appropriations Act of 2021 Notice section at the front of this Benefit Book for details.

PLAN ADMINISTRATION

NOTE: This section is not a part of Your Benefit Book. The Claims Administrator is not responsible for any statements contained herein that are not set forth in the Administrative Services Agreement or the Benefit Book.

- **Plan Name: Northern Buckeye Health Plan**
- **Plan Sponsor: Northern Buckeye Health Plan**
-
- **Plan Number: 501**
- **Employer IRS I.D. Number: 45-4109527**
- **Type of Plan:** The Plan is an Employee welfare benefit plan providing group medical benefits.
- **Plan Year Ends: 12/31/2023**
- **Type of Administration/Funding:** Medical benefits are furnished under a health care plan funded by the Plan Sponsor on a self-funded basis with claims being administered by Community Insurance Company on behalf of Northern Buckeye Health Plan, NW Division of OHI.
- **Plan Administrator and Named Fiduciary: Northern Buckeye Health Plan**
- **Agent for Service of Legal Process: Tom Dierling**

GET HELP IN YOUR LANGUAGE

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

You have the right to get this information and help in Your language for free. Call the Member Services number on Your Identification Card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for Members with visual impairments. If You need a copy of this document in an alternate format, please call the Member Services telephone number on the back of Your Identification Card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian

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

Amharic

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

Arabic

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

Armenian

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

Bassa

M̀ ɓédé̩ dyí-ɓèdɛ̀in-dèɔ̀ ɓɛ́ m̀ ké bɔ̃̌ nìà kɛ kè gbo-kpá- kpá dyé dé m̀ ɓídí-wùdùǔn ɓó pídyi. Ɖá mɛ́ɓà jè gbo-gmɔ̀ Kpòɛ̀ nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̀ɔ kɔ̃ɛ ɓɛ́ m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali

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

Burmese

(TTY/TDD: 711)

Chinese

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

Dinka

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

Dutch

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

Farsi

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

French

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

German

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

Greek

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

Gujarati

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

Haitian

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

Hindi

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

Hmong

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

Igbo

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

llokano

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

Indonesian

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

Italian

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

Japanese

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

Khmer

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

Kirundi

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

Korean

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

Lao

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

Navajo

Bee ná ahoot’i’ táá ni nizaad k’ehjí niká á a’doowol t’áá jíík’e. Naaltsoos bee atah nílínígíí bee néého’dólzingo nanitinígíí béésh bee hane’í bikáá’ áaji’ hodíílnih. Naaltsoos bee atah nílínígíí bee néého’dólzingo nanitinígíí béésh bee hane’í bikáá’ áají’ hodíílnih. (TTY/TDD: 711)

Nepali

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

Oromo

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

Pennsylvania Dutch

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

Polish

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

Portuguese-Europe

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

Punjabi

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

Romanian

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

Russian

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

Samoan

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

Serbian

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

Tagalog

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

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian

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

Urdu

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

Vietnamese

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

Yiddish

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

Yoruba

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

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield Healthcare Plan of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded Plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO Plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare Health Services Insurance Corporation (Compcare) or Wisconsin Collaborative Insurance Company (WCIC). Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

2023 PRESCRIPTION DRUG BENEFIT

Schedule of Benefits NBHP High Deductible Health Plan	
Benefits and Provisions	**Your Cost**
Deductible and Out-of-Pocket Maximum per Calendar Year	There is no separate annual Out-of-Pocket Maximum for Prescription Drug benefits. Medical and Prescription co-pays, coinsurance and deductibles are combined for purposes of determining if You have satisfied Your annual Medical Out-of-Pocket Maximum. You pay the total allowed amount for the cost of **covered** Prescription Drugs until You meet Your annual Deductible. After Your annual Deductible is met, You will pay the copay amount.
Prescription Drug Card Program (*up to 34-day supply through participating pharmacies)*	• Deductible then 20% ***Once the annual Out-of-Pocket Maximum has been met****, the Plan will pay 100% for* ***covered*** *Prescription Drugs for the remainder of the Calendar Year.*
Limitation on Filling Maintenance Drugs	A maximum of 3 fills are allowed at retail (up to 34-day supply) for a new maintenance drug. After that, a 90-day supply of the drug must be filled via Home Delivery/Mail Order pharmacy or Smart90 Retail Pharmacy, or You pay 100% of the prescription cost.
Specialty Pharmacy *(up to 34-day supply)*	Provides injectable and other specialty medications to members with free delivery to Your home or Your Physician's office. Contact Express Scripts Specialty Pharmacy for more information on a specific Specialty medication.
Brand When Generic is Available	You must pay the cost difference between the brand and generic drug, in addition to Your copay or coinsurance.
Prior Authorizations	Contact Express Scripts with questions regarding quantity limitations or prior authorizations.
Coordination of Benefits	The Plan does not cover any secondary claims on Prescription Drugs. Prescription Drugs will only be paid on claims incurred by members with primary Prescription Drug coverage through this Plan, meaning there is no Coordination of Benefits for Prescription Drug claims, even when another plan has paid primary.

For additional information about Your Prescription Drug benefits, including the applicable copay for a medication, please contact Express Scripts Customer Service at 866-275-0044 or online at express-scripts.com.

PRESCRIPTION DRUG BENEFITS

Prescription Drug benefits are provided through the Pharmacy Benefit Manager (PBM), Express Scripts. All general provisions in this book regarding eligibility and general administration also apply to the Prescription Drug benefits provided by the Plan. All Benefits will be paid as stated in the Schedule of Benefits for charges made by a participating pharmacy for treatment of You or Your eligible Dependent(s). A covered charge is considered made on the date the prescription is dispensed by the pharmacist.

In the event of a direct conflict between the general provisions of this Book and the provisions in this Prescription Drug section, the provisions of this Prescription Drug section shall prevail.

The Plan does not cover any secondary claims on Prescription Drugs. Prescription Drugs will only be paid on claims incurred by members with primary Prescription Drug coverage through the Plan, meaning there is no Coordination of Benefits for Prescription Drug claims, even when another plan has paid primary.

Covered Prescription Drugs

The Plan Prescription Drug benefit covers a wide variety of Prescription Drugs. Prescription Drugs are generally drugs that, by law, may be dispensed only by prescription. Covered Prescription Drugs generally include generic drugs and brand-name drugs. The Plan also maintains a Prescription Drug Formulary, which is a list of preferred drugs that members can obtain for lower copays and to help save them money. An expert panel of physicians and pharmacists carefully review the drugs on the Prescription Drug Formulary for safety, quality, effectiveness and cost. The Prescription Drug Formulary and conditions of drug coverage under the Plan is subject to change.

To find out whether a particular drug is included on the Prescription Drug Formulary and covered under the Plan, and what conditions of coverage (if any) may apply, please contact Express Scripts Customer Service at 866-275-0044 or online at www.express-scripts.com. A pharmacist can also check whether a medication is on the Prescription Drug Formulary or covered at any time.

Covered Pharmaceutical Products

The Plan also covers insulin, diabetic testing devices, test strips, syringes, and needles.

Contraception

The Plan includes coverage for several types of contraceptives including generic hormonal and emergency oral contraceptives, diaphragms, and the Mirena IUD at no cost to You, up to age 50. Multi-source brand contraceptive agents will be covered if prescribed and dispensed as written. After age 50, contraceptives will continue to be covered, however, applicable cost-share will be due (see Schedule of Benefits for Your cost-share).

Drugs and Pharmaceuticals Not Covered

Some Prescription Drugs and pharmaceutical products are not covered under, or are excluded from, the Prescription Drug benefit, which means there are no alternatives to try or exceptions to coverage. The following list of benefit exclusions outline general categories of Prescription Drugs and pharmaceutical products that are not covered under the Plan. Other drugs may be excluded from the Prescription Drug Formulary as noted elsewhere in this Benefit Book. To check whether a medication is excluded please contact Express Scripts Customer Service at 866-275-0044 or online at www.express-scripts.com.

The Plan does not pay for any of the following medications or pharmaceutical products listed:

1. Federal Legend non-drugs and Non-Federal Legend drugs or non-drugs
2. Investigational Drugs
3. Diagnostic Medications
4. Experimental Drugs
5. Fertility Agents
6. Medications with OTC Equivalents (such as Claritin, Allegra)
7. Medications furnished on an in-patient basis covered under any other carrier providing group coverage for prescription legend drugs or insulin
8. Pharmaceutical Products used for Cosmetic purposes – All Hypopigmentation, Renova, Vaniqa (except Topical Tretinoin with Prior Authorization for member > 25 years of age)

9. Lifestyle Brand medications
10. Medications to treat Impotency
11. Prescription Vitamins (except prenatal)
12. Biological, Allergy Sera, and Toxoids
13. Nutritional Supplements
14. Anti-Obesity Preparations
15. Abortifacients
16. Yohimbine
17. Insulin Pump Supplies (available as Durable Medical Equipment with Medical Necessity)
18. Medical Supplies (e.g. Ostomy Supplies)
19. Over-the Counter Products
20. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed above.
21. Dental Fluoride Products

Long-Term Maintenance Medication

You have two ways to get up to a 90-day supply of Your Long-Term Maintenance Medication (those drugs You take regularly for ongoing conditions). You can conveniently fill those prescriptions either through Home Delivery/Mail Order from the Express Scripts Pharmacy or at a Retail Pharmacy in the Smart90 network.

Home Delivery/Mail Order Drug Benefit

The benefit offers a Home Delivery/Mail Order service which delivers required Prescription Drugs directly to Your home after a prescription copay has been made (see Schedule of Benefits for copay amount). The Home Delivery/Mail Order drug benefit permits up to a 90-day supply of medication and up to one year of refills upon authorization.

You should receive a packet providing complete details on how to use Your Home Delivery/Mail Order drug benefit. If You have any questions regarding this aspect of Your coverage, please contact Express Scripts Customer Service at 866-275-0044 or online at www.express-scripts.com.

Smart90 Retail Pharmacy Benefit

The benefit provides up to a 90-day supply of medication to be filled for pickup at a participating Smart90 Retail Pharmacy. To locate a participating pharmacy, please contact Express Scripts Customer Service at 866-275-0044 or online at www.express-scripts.com.

Specialty Drug Pharmacy Benefit

Certain specialty medications may be required to be purchased through Accredo, manager of the Express Scripts Specialty Pharmacy program. These medications are costly, require special storage or handling, are for long-term use, and require careful monitoring and management. You will be notified by the pharmacy at the time of purchase if a particular drug is in the Specialty Pharmacy program. The Specialty Pharmacy will coordinate fast shipment to the location a member chooses, such as Your home or Your Physician's office. Alternatively, if Accredo indicates the drug cannot be dispensed, please contact the Accredo Customer Service number at 800-803-2523, to determine how the specialty drug that has been prescribed must be dispensed.

Prescription Coverage Management Program

- Express Scripts identifies quality and cost opportunities based on medical criteria recognized by the medical and pharmacy communities at the point a prescription is placed to be filled.
- Express Scripts looks for possible conflicts with the diagnosis and standard drug use; possible multi-drug interactions; untried first or second line medication options, etc.
- Express Scripts contacts Your Physician on Your behalf to discuss the opportunity. The Physician has the final determination for prescription use, NOT Express Scripts.
    - The determination (whether the Physician re-issues the prescription or supports the first order) is maintained in the Express Scripts database for one year. Prior to the year expiration, a letter will be mailed to You indicating the review process needs to be updated if continued use of the medication is needed.

Quantity Level Limits
Note that certain medications may have specific quantity limitations that are not the standard supply limit. You will be notified if this is the case either by the pharmacist or through the Home Delivery/Mail Order process.

Prescription Drug Formulary
The Prescription Drug Formulary is a list of Federal Drug Administration (FDA) approved Prescription Drugs and supplies developed by a Pharmacy and Therapeutics Committee. The list reflects the current clinical judgment of practicing health care practitioners—based on a review of current data, medical journals, and research information. The Prescription Drug Formulary is used as a guide for determining Your costs for each prescription.

Prior Authorization Requirements
Certain medications may need to have additional clarifications or authorizations made prior to being dispensed. You will be provided with details through the Home Delivery/Mail Order process if this situation should occur when using the program. If this should occur during Your purchase of a retail drug or Smart90 Retail Pharmacy, the pharmacist will provide You with a number to contact the pharmacy vendor and initiate the process.

Step Therapy
Certain Prescription Drugs are subject to Step Therapy review. Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug; and stepping up through a sequence of alternative drug therapies, if a preceding treatment option fails. If Step Therapy criteria are not met, Prior Authorization will be required. Your doctor may initiate the Prior Authorization process by contacting Express Scripts. If approved, Your prescription will be filled within any stated plan limits. If the medication is not approved for coverage, You will be responsible for paying the full cost of the drug. However, rejection of coverage may be appealed. To appeal, You or Your doctor must follow the procedure outlined in the Appeals section.

Vaccines
Many diseases are preventable through the use of vaccinations. To help You stay healthy, the Plan covers vaccines for the flu and other illnesses administered through Your local retail pharmacy, at no cost to You. Vaccines administered at Your retail pharmacy typically do not require an appointment and are the same effective medications administered in Your physician's office.

APPEALING A PHARMACY BENEFITS CLAIM

When appealing a pharmacy benefits claim, please submit a written appeal directly to Express Scripts, the pharmacy benefits manager, at the pertinent address below:

For an administrative review* appeal:
Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587
VIA FAX: (877) 328-9660

For a clinical review* appeal:
Express Scripts
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
VIA FAX: (877) 852-4070
* Please review Your initial benefits denial letter for additional information on whether Your appeal is clinical or administrative.

CLAIMS PROCEDURES

An explanation of benefits or other written or electronic notification will be provided by the Pharmacy Benefits Manager, showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "**Adverse Benefit Determination**." An Adverse Benefit Determination also includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. An Adverse Benefit Determination (other than a rescission of coverage) is subject to the claims provisions detailed below.

The Pharmacy Benefits Manager will notify You of an Adverse Benefit Determination within 30 days after receipt of a post-service claim (and within 15 days after receipt of a pre-service claim). However, in certain cases an extension of up to 15 days may be utilized if the Pharmacy Benefits Manager determines that the extension is necessary due to matters beyond the control of the Plan and You are notified prior to the expiration of the initial 30-day or 15-day period, as applicable, of the circumstances requiring the extension of time and the date by which the Pharmacy Benefits Manager expects to render a decision. If such an extension is necessary due to Your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and You shall be given at least 45 days within which to provide the specified information. A notice of Adverse Benefit Determination will include the following:

- Sufficient information to identify the claim involved, including the date(s) of service, health care provider, and claim amount.
- The specific reason or reasons for the Adverse Benefit Determination, as well as the Plan's standard that was used in denying the claim, if applicable, and including identifying denial codes and providing their meaning.
- Reference to specific Plan provisions on which the Adverse Benefit Determination is based.
- A statement that if You think a coding error may have caused this claim to be denied, You have the right to have billing and diagnosis codes sent to You.
- A description of any additional material or information necessary for You to perfect the claim and an explanation of why such material or information is necessary.
- A description of the Plan's first level appeal procedures and the time limits applicable to such procedures, including information on how to initiate an appeal.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in

the notice of Adverse Benefit Determination; or the notice will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon written request.

- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon written request.

- A description of the availability of assistance from the Ohio Superintendent of Insurance ("**Superintendent**"), including the mailing address, telephone number and web site of the Superintendent's office of Consumer Affairs. The mailing address is 50 West Town Street, Suite 300, Columbus, OH 43215. The telephone number is 800-686-1526 / 614-644-2673, and the website is: https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

FIRST LEVEL APPEALS PROCEDURE

If You receive an Adverse Benefit Determination, You or Your authorized representative may appeal the determination by filing a written application through Express Scripts, the Pharmacy Benefits Manager. Be sure to say why You think the decision is not correct—in other words, why You think Your claim should be paid. In appealing an Adverse Benefit Determination, the Pharmacy Benefits Manager will provide You or Your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon written request and free of charge, reasonable access to, and copies of, all documents, records, the claim file, and other information relevant to the claim.
- A full and fair review that takes into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Pharmacy Benefits Manager, as well as any new or additional rationale relied upon by the Pharmacy Benefits Manager in reaching its determination on appeal, that differs from that which the Pharmacy Benefits Manager relied on in its Adverse Benefit Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Pharmacy Benefits Manager's determination is required to be provided to give You a reasonable opportunity to respond prior to that date.
- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate individual who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, that the appropriate individual shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Upon written request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with Your Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

A first level appeal must be filed, in writing, within 180 days after the Adverse Benefit Determination is received. An appeal will be considered filed on the date it is received. An appeal for claims filed beyond the timely filing date will not be considered. The Pharmacy Benefits Manager will notify You or Your authorized representative of its determination within 60 days after receipt of an appeal that relates to a post-service claim, or within 30 days of an appeal that relates to a pre-service claim. The determination notice:

- Will contain sufficient information to identify the claim involved, including the date(s) of service, health care provider, claim amount, denial codes and their meaning, as well as the Plan's standard used in denying the claim.
- Will be in writing, setting forth specific reasons for the decision and reference to the specific Plan provisions upon which the determination is based.
- Will contain a statement that You are entitled to receive, upon written request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- Will contain a description of the Plan's external review processes, including information on how to initiate a second and third level appeal (if applicable).
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to You upon written request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon written request.
- Will contain a description of the availability of assistance from the Superintendent, including the mailing address, telephone number and web site of the Superintendent's office of Consumer Affairs. The mailing address is 50 West Town Street, Suite 300, Columbus, OH 43215. The telephone number is 800-686-1526 / 614-644-2673, and the website is: https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp.

FINAL LEVEL (EXTERNAL) APPEALS PROCEDURE

Circumstances Triggering the Opportunity for External Review: If Your initial appeal is denied, in whole or in part, such denial is called a "**Final Internal Adverse Benefit Determination**." You or Your authorized representative may submit an external appeal of the Final Internal Adverse Benefit Determination (known as a "**request for external review**") by filing a written application through the Pharmacy Benefits Manager, under four distinct circumstances. First, a request for external review may be sought where the underlying determination involves medical necessity, appropriateness, health care setting and/or level of care or effectiveness. Such a request will be reviewed by an Independent Review Organization ("**IRO**") (see below).

Second, You may request an external review for treatment the Pharmacy Benefits Manager has determined to be experimental or investigational (except when the requested treatment is explicitly excluded under the terms of the Plan) if Your treating physician certifies that 1) standard health care services have not been effective in improving Your condition, 2) standard health care services are not medically appropriate for You, or 3) there is no available standard health care service covered by the Plan that is more beneficial than the requested treatment. This request, if allowed, will similarly be reviewed by an IRO.

Third, a request for external review may be sought based on a contractual issue that does not involve medical judgment or any medical information. Such a request will be reviewed by the Superintendent. The Superintendent will determine whether the health care service at issue is a service covered under the terms of the Plan. If the determination requires a medical judgment or is based on medical information, however, the Superintendent will inform the Pharmacy Benefits Manager, who will initiate an external review with an IRO.

Finally, for an adverse benefit determination where emergency medical services have been determined to be not medically necessary or appropriate *after an external review*, You will have the opportunity to request a further external review by the Superintendent.

How to File a Request for External Review: To file a request for external review, You must request such an appeal in writing with the Pharmacy Benefits Manager. When filing a request for an external review, You will be required to authorize the release of Your medical records as necessary to conduct the external review.

An external appeal must be filed within 180 days after the Final Internal Adverse Benefit Determination is received. The Plan will pay the cost of the external review, including the cost of any external review that is required at the direction of the Superintendent.

Following receipt of a request for external review, the Pharmacy Benefits Manager will review the request to determine whether it is complete, including whether You have exhausted the Plan's first level appeal process. If complete, and reviewable by an IRO, the Superintendent shall assign an IRO from the list of organizations maintained by the Superintendent to conduct the external review. The Superintendent shall notify the Pharmacy Benefits Manager of the name of the assigned IRO. The Pharmacy Benefits Manager shall then notify You in writing of the acceptance of the final level review. Depending on the type of request for external review, this notice will include the name and contact information for either the assigned IRO or Superintendent (whichever is applicable) for the purpose of submitting additional documentation. The notice will also include a statement that You may submit in writing to either the IRO or Superintendent (whichever is applicable) within ten business days following the date of receipt of the notice, any additional information that should be considered when conducting the final review. (If the request for an external review is not complete, the Pharmacy Benefits Manager shall inform You in writing, and include what information is needed to make the request complete. If the Pharmacy Benefits Manager denies a request for an external review on the basis that the Final Internal Adverse Benefit Determination is not eligible for an external review, the Pharmacy Benefits Manager shall notify You in writing the reason for the denial, and that the denial may be appealed to the Superintendent.)

Within five days after the receipt of a request for an external review, the Pharmacy Benefits Manager must provide to the assigned IRO or Superintendent (whichever is applicable) the documents and any information considered in making the Final Internal Adverse Benefit Determination. If the Pharmacy Benefits Manager fails to timely provide the documents and information, the IRO may terminate the final review and make a decision to reverse the Final Internal Adverse Benefit Determination. Within one business day after making that decision, the IRO must notify You, the Pharmacy Benefits Manager and the Superintendent. The IRO may also grant a request from the Pharmacy Benefits Manager for more time to provide the required information.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim without deference to the Pharmacy Benefits Manager and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO shall also consider the following additional information if available:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Pharmacy Benefits Manager, You or Your treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to these terms;
- Appropriate practice guidelines, including evidence-based standards and other guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Pharmacy Benefits Manager; and
- The opinion of the IRO's clinical reviewer(s) after considering the other sources referenced above.

The IRO must provide written notice of its decision within 30 days after it receives the request for the external review. The notice must be provided to You, the Pharmacy Benefits Manager, and the Superintendent, and must include the following:

- A general description of the reason for the request for the review with enough information to identify the claim;
- The date the IRO was assigned by the Superintendent to conduct the external review;
- The dates over which the external review was conducted;
- The date of the IRO's decision;

- References to the evidence or documentation, including evidence-based standards, considered in reaching its decision; and
- The rationale for the decision.

External Reviews Involving Experimental and Investigational Treatment. With respect to external reviews involving Experimental and Investigational treatment, the IRO that is assigned by the Superintendent must select at least one clinical reviewer to conduct the external review and make a decision to uphold or reverse the Final Internal Adverse Benefit Determination based on the clinical reviewer(s) opinion. The IRO will select physicians or other health care professionals who meet the follow minimum qualifications to conduct the clinical review:

- The clinical reviewer(s) assigned by the IRO to conduct the external review shall have the same license as the health care provider of the service in question;

- The clinical reviewer(s) must be an expert in the treatment of the medical condition that is the subject of the external review through clinical experience, within the last three years, in the treatment of the covered person's condition and have knowledge of the requested health care service;

- The clinical reviewer(s) must hold a non-restricted license in the United States, and for physicians, hold a current certification by a recognized American medical specialty board in the area(s) appropriate to the subject of the external review; and

- The clinical reviewer(s) must have no history of disciplinary actions or sanctions that would raise a question as to the clinical reviewer's physical, mental, or professional competence or moral character.

The clinical reviewer(s) shall review all the information considered in making the Final Internal Adverse Benefit Determination, as well as any additional information previously provided by You within ten business days of receipt of notice by the Pharmacy Benefits Manager, that the request for external review was complete.

The clinical reviewer(s) is not bound by the conclusions reached by the Pharmacy Benefits Manager. The clinical reviewer will provide a written opinion to the IRO which shall include:

- A description of Your condition;

- A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested therapy is more likely than not to be more beneficial to You than standard therapies, and that the adverse risks of the requested therapy would not be substantially greater than those of available standard health care services;

- A description and analysis of any medical or scientific evidence considered in reaching the opinion;

- A description and analysis of any evidence-based standard considered; and

- Information on whether the reviewer's rationale for the opinion is based on whether the requested health care service has been approved by the Federal Food and Drug Administration, if applicable for the condition, and whether medical or scientific evidence, or evidence-based standards, demonstrate that the expected benefits of the requested services are more likely than not to be beneficial to You than any available standard services, and that the adverse risks of the services would not be substantially greater than those of available standard services.

If there are multiple clinical reviewers, and the majority of the reviewers recommend the service should not be covered, the IRO will uphold the Final Internal Adverse Benefit Determination. If the majority of clinical reviewers recommend the service should be covered, the IRO will reverse the Final Internal Adverse Benefit Determination. If the reviewers are evenly split as to whether the Final Internal Adverse Benefit Determination should be reversed or upheld, the IRO shall obtain the opinion of an additional clinical reviewer in order for the IRO to make a decision based on the opinions of a majority of the clinical reviewers. The additional clinical reviewer selected shall use the

same information to reach an opinion as the clinical reviewers who have already submitted their opinions. The selection of the additional clinical reviewer shall not extend the time within which the assigned IRO is required to make a decision.

Reversal of the Plan's decision. Upon receipt of a notice of an external review decision reversing the Final Internal Adverse Benefit Determination, the Plan must immediately pay the claim. For questions about Your appeal rights or for assistance, You can contact:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp
File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making a non-urgent care determination could seriously jeopardize the life, health, or safety of the patient or others due to the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care of treatment that is the subject of the claim. NOTE: Urgent pharmacy appeals must be submitted by phone at (800) 753-2851 or fax at (877) 852-4070 and will be considered within 48 hours after receipt of the appeal. Claims and appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call or fax identifies the appeal as urgent.