

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

**Anthem Student Advantage
Anthem SHP PPO
The President and Trustees of Colby College
08-01-2025**

Certificate of Coverage

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

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

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

Right to Examine

If this Certificate of Coverage is provided to you as a new Member, and if you decide not to accept this Certificate, return it to our home office (Anthem Blue Cross and Blue Shield; 2 Gannett Drive, South Portland, ME 04106-6911) within 10 days after its delivery date. Please include a written request to cancel it. We will then refund any Subscription Charges less any claims paid under this Certificate.



Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc.
Independent licensee of the Blue Cross and Blue Shield Association.

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Notices Required by State Law

Paying Subscription Charges and Renewal

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

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

Network Disclosure Notice

IMPORTANT NOTICE ABOUT YOUR PROVIDER NETWORK AND BENEFITS: There are hospitals, health care facilities, physicians or other health care providers that are not included in this plan's network. Your financial responsibilities for payment of covered services, including "cost shares," such as co-insurance, co-payments, and out of pocket maximums may be higher if you use a non-network provider. Additionally, you may have some cost-sharing for preventive benefits if you do not use a network provider. Please refer to the online provider directory available at Anthem.com to determine if a particular provider is in the network, or contact Member Services for assistance.

Network Name: Blue Choice

The Service Area for this plan is the State of Maine.

Benefits are available both inside and outside the State of Maine. There are benefits for out-of-area non-Emergency Care/non-Urgent Care services. Please see the "Claims Payment" section for further details on out-of-area services through Our Inter-Plan program.

Surprise Billing Protection Notices

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

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

This section describes the provisions of both sets of laws.

Consolidated Appropriations Act of 2021 (CAA)

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

Surprise Billing Claims

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

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

No Surprises Act Requirements

Emergency Services

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

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

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

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

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

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

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

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

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

Out-of-Network Air Ambulance Services

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

How Cost-Shares Are Calculated

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

Appeals

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

Provider Directories

Anthem updates the list of participating providers at least every 30 days as required by Maine law. In accordance with federal law, Anthem confirms the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from Anthem that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost-shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

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

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

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

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

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

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

Maine's Surprise Billing Law

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

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

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

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

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

Which Surprise Bills are Eligible for Independent Dispute Resolution

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

Process to Submit a Surprise Bill for Dispute Resolution

1. The claim must involve a surprise bill for covered emergency services.
2. The out-of-network provider requesting IDR (the "applicant") shall submit an application to the Maine Bureau of Insurance in a form and manner prescribed by the Superintendent.

The Dispute Resolution Process

1. Within three business days after an application has been determined to be eligible, the Independent Dispute Resolution Entity (IDRE) will assign an arbitrator and notify the patient, the provider or providers, and, if applicable, the carrier or self-insured plan.
2. The arbitrator may request information at any time from the patient, the provider or providers, and the carrier, and shall advise the requested party that if a partial response or no response is received, the dispute will be decided based on the available information. Any party shall provide the information requested within the time requested, which shall be no less than five business days after the request is received, and shall attest that the information provided is true and complete.
3. The IDRE shall issue its decision within thirty days after its receipt of a completed application.
4. If the IDRE determines the carrier's payment is reasonable, payment for the dispute resolution process is the responsibility of the out-of-network provider. When the independent dispute resolution entity determines the out-of-network provider's fee is reasonable, payment for the dispute resolution process is the responsibility of the carrier. When a good faith negotiation directed by the IDRE results in a settlement between the carrier and the out-of-network provider, the carrier and the out-of-network provider shall evenly divide and share the prorated cost for dispute resolution.
5. The party responsible for payment of the IDRE's fee, or its share of the fee in the case of a negotiated settlement, must pay the IDRE within 90 days after the issuance of the decision or submission of the settlement agreement.

Federal Patient Protection and Affordable Care Act Notices

Access to Obstetrical and Gynecological (ObGyn) Care

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

Additional Federal Notices

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

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

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

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

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

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

Notice Regarding Breast Cancer Patient Protection Act

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

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

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

Mental Health Parity and Addiction Equity Act

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

Special Enrollment Notice

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

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

- The Student's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility

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

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

Introduction

Welcome to Anthem!

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

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

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

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

Many words used in the Booklet have special meanings (e.g., College, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Blue Cross and Blue Shield or any of our subsidiaries, affiliates, subcontractors, or designees. The words "you" and "your" mean the Member, Student and each covered Dependent, if applicable.

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

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of our Member Services call centers. Simply call the Member Services phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Kathleen S. Kiefer
Corporate Secretary

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Schedule of Benefits PPO

Actuarial Value: 60%

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

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

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Claims Payment" section for more details.

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

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

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

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

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

Benefit Period	Plan Year
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Deductible	In-Network	Out-of-Network
When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies. Copayments and Coinsurance are separate from and do not apply to the Deductible.		
Per Member	\$0	\$0

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

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

Reminder: Except for Surprise Billing Claims, your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.

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

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	\$2,350	\$5,000

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

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

Once the Out-of-Pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period.

Important Notice about Your Cost Shares

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

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

Benefits	In-Network	Out-of-Network
Acupuncture	20% Coinsurance	40% Coinsurance
Acupuncture Benefit Maximum	30 visits per Benefit Period In- and Out-of-Network combined	
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
<p>Ambulance Services (Ground, Air, and Water) Emergency Services</p> <p>Standard: For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment.</p>	20% Coinsurance	
<p>Ambulance Services (Ground, Air, and Water) Non-Emergency Services</p> <p>For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment.</p> <p>Important Note: All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.</p>	<p>20% Coinsurance</p> <p>Only emergency services are covered when an out of network provider is used.</p>	

Benefits	In-Network	Out-of-Network
Autism Services	Benefits are based on the setting in which Covered Services are received.	
Bedside Visits (International Students and Domestic Students)	100% of actual charge for covered medical expenses subject to \$5,000 maximum per policy year	
Behavioral Health Services	See “Mental Health and Substance Use Disorder Services.”	
Blood Transfusions	Benefits are based on the setting in which Covered Services are received	
Cardiac Rehabilitation	See “Therapy Services.”	
Cellular and Gene Therapy Services • Precertification required	Benefits are based on the setting in which Covered Services are received	
Chemotherapy	See “Therapy Services.”	
Chiropractor Services	See “Therapy Services.”	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
COVID-19 Coverage for screening, testing and immunization	No Copayment, Deductible or Coinsurance	Benefits are based on the setting in which Covered Services are received

Benefits	In-Network	Out-of-Network
<p>Dental Services for Members through Age 18:</p> <p>Notes:</p> <p>To get In-network benefits, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call the number on the back of your ID card.</p> <p>Anesthesia for dentistry is available for certain members. Please see your Certificate of Coverage for details.</p>		
Diagnostic and Preventive Services	0% Coinsurance	0% Coinsurance
Basic Restorative Services	0% Coinsurance	20% Coinsurance
Endodontic Services	0% Coinsurance	20% Coinsurance
Periodontal Services	50% Coinsurance	50% Coinsurance
Oral Surgery Services	50% Coinsurance	50% Coinsurance
Major Restorative Services	50% Coinsurance	50% Coinsurance
Prosthodontic Services	50% Coinsurance	50% Coinsurance
Dentally Necessary Orthodontic Care	50% Coinsurance	50% Coinsurance
Dental Services (All Members / All Ages)	Benefits are based on the setting in which Covered Services are received.	
<p>Diabetes Services, Equipment, Education, and Supplies</p> <p>Screenings for gestational diabetes are covered under "Preventive Care."</p>	20% Coinsurance	40% Coinsurance
<p>Diagnostic Services</p> <ul style="list-style-type: none"> • Diagnostic Labs • All Other Diagnostic Services 	<p>20% Coinsurance</p> <p>Benefits are based on the setting in which Covered Services are received</p>	40% Coinsurance
Dialysis	See "Therapy Services."	

Benefits	In-Network	Out-of-Network
<p>Durable Medical Equipment (DME) Medical Devices, and Supplies</p> <p>Durable Medical Equipment</p> <p>Orthotics</p> <p>Prosthetics for limb replacement</p> <p>All Other Prosthetics</p> <p>Wigs</p> <p>Medical and Surgical Supplies</p>	<p>20% Coinsurance</p> <p>20% Coinsurance</p> <p>20% Coinsurance</p> <p>20% Coinsurance</p> <p>20% Coinsurance</p> <p>20% Coinsurance</p>	<p>40% Coinsurance</p> <p>40% Coinsurance</p> <p>40% Coinsurance</p> <p>40% Coinsurance</p> <p>40% Coinsurance</p> <p>40% Coinsurance</p>
<p>The cost-shares listed above apply when your Provider submits separate bills for the equipment or supplies.</p>		
<p>Hearing Aids Benefit Maximum for Members through age 18:</p> <p>Benefit Maximum for Members age 19 and over:</p> <p>Wigs (when needed after cancer treatment)</p>	<p>One hearing aid per hearing-impaired ear every 36 months per benefit period</p> <p>Limited to \$3,000 per hearing aid for each hearing-impaired ear every 36 months</p> <p>One wig per Benefit Period In- and Out-of-Network combined</p>	
<p>The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices and supplies, hearing aids and wigs will be based on the Maximum Allowed Amount for a standard item that is Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and you will be required to pay any costs that exceed the Maximum Allowed Amount. Please check with your Provider or contact us if you have questions about the Maximum Allowed Amount.</p>		
<p>Early Childhood Intervention Services</p> <ul style="list-style-type: none"> For Members up to 36 months of age. 	<p>Benefits are based on the setting in which Covered Services are received</p>	
<p>Emergency Room Services</p>		
<p>Emergency Room</p> <p>As described in the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet, for Emergency Services Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable and followed the notice and consent process. Please refer to the Notice at the beginning of this Booklet for details.</p>		
<ul style="list-style-type: none"> Emergency Room Facility Charge 	<p>20% Coinsurance</p>	

Benefits	In-Network	Out-of-Network
<ul style="list-style-type: none"> • Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon) • Emergency Room Doctor Charge (Mental Health / Substance Use Disorder) • Other Facility Charges (including diagnostic x-ray and lab services, medical supplies) • Advanced Diagnostic Imaging (including MRIs, CAT scans) 	20% Coinsurance	20% Coinsurance
Fertility	See “Maternity and Reproductive Health Services”	
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See “Therapy Services” for details on Benefit Maximums	
<p>Home Health Care</p> <p>Covered Services include but are not limited to:</p> <ul style="list-style-type: none"> - Intermittent skilled nursing services by an R.N. or L.P.N. - Medical / social services - Diagnostic services - Nutritional guidance - Training of the patient and/or family/caregiver - Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us. - Therapy Services - Medical supplies - Durable medical equipment <ul style="list-style-type: none"> • Home Health Care Visits from a Home Health Care Agency • Home Dialysis • Home Infusion Therapy / Chemotherapy • Specialty Prescription Drugs for infusion / injection – Other than Chemotherapy • Other Home Care Services / Supplies 	20% Coinsurance 20% Coinsurance 20% Coinsurance 20% Coinsurance 20% Coinsurance	40% Coinsurance 40% Coinsurance 40% Coinsurance 40% Coinsurance 40% Coinsurance

Benefits	In-Network	Out-of-Network
Home Health Care Benefit Maximum	Unlimited	
Home Infusion Therapy	See "Home Care."	
Hospice Care <ul style="list-style-type: none"> • Home Hospice Care • Bereavement • Inpatient Hospice • Outpatient Hospice • Respite Care 	20% Coinsurance 20% Coinsurance 20% Coinsurance 20% Coinsurance 20% Coinsurance	40% Coinsurance 40% Coinsurance 40% Coinsurance 40% Coinsurance 40% Coinsurance
This Plan's Hospice benefit will meet or exceed Medicare's Hospice benefit.		
Human Organ and Tissue Transplant See "Inpatient Services" section for additional information regarding applicable cost shares. Please call us as soon you think you may need a transplant to talk about your benefit options. You must do this <i>before</i> you have an evaluation and/or work-up for a transplant. <ul style="list-style-type: none"> • Transportation and Lodging Limit Human Leukocyte Antigen Testing – Limited to one test per lifetime per member to a maximum of \$150. Any charges incurred in excess of \$150 will be the responsibility of the member.	Benefits are based on the setting in which Covered Services are received Covered as approved by us 0% Coinsurance No Deductible	
Inborn Error of Metabolism: Medical Food	Benefits are based on the setting in which Covered Services are received	
Infant Formula	Benefits are based on the setting in which Covered Services are received	
Inpatient Services		

Benefits	In-Network	Out-of-Network
Facility Room & Board Charge:		
<ul style="list-style-type: none"> • Hospital / Acute Care Facility • Skilled Nursing Facility/Rehabilitation <p style="margin-left: 20px;">Benefit Maximum: 150 Days per Benefit Period for In-Network and Out-of-Network combined.</p> <ul style="list-style-type: none"> • Ancillary Services <p>Doctor Services when billed separately from the Facility for:</p> <p>General Medical Care / Evaluation and Management (E&M)</p> <p>Surgery</p>	<p style="text-align: center;">20% Coinsurance</p> <p style="text-align: center;">20% Coinsurance</p> <p style="text-align: center;">20% Coinsurance</p> <p style="text-align: center;">20% Coinsurance</p> <p style="text-align: center;">20% Coinsurance</p>	<p style="text-align: center;">40% Coinsurance</p> <p style="text-align: center;">40% Coinsurance</p> <p style="text-align: center;">40% Coinsurance</p> <p style="text-align: center;">40% Coinsurance</p> <p style="text-align: center;">40% Coinsurance</p>
Maternity and Reproductive Health Services		
<ul style="list-style-type: none"> • Maternity • Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) 	<p style="text-align: center;">20% Coinsurance</p> <p style="text-align: center;">20% Coinsurance</p>	<p style="text-align: center;">40% Coinsurance</p> <p style="text-align: center;">40% Coinsurance</p>
<ul style="list-style-type: none"> • Inpatient Services (Delivery) 	See "Inpatient Services"	
<p>Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.</p>		
Fertility	Benefits are based on the setting in which Covered Services are received	
Mental Health and Substance Use Disorder Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
<p>Mental Health and Substance Use Disorder Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section for details.</p>		
Occupational Therapy	See "Therapy Services."	

Office and Home* Visits

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

If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the “Outpatient Facility Services” or “Outpatient Facility Services - Site of Service Ambulatory Surgery and Radiology Centers” section, based on where services are received. Please refer to those sections for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.

<ul style="list-style-type: none"> Primary Care Physician / Provider (PCP) (Including In-Person and/or Virtual Visits) Includes Ob/Gyn visits <p>Please note: There is no member cost share In-Network for the first primary care office visit in each plan year. First primary care visit includes Primary Care In-Person and/or Virtual Visits, Telemedicine/Telehealth, Retail Health Clinic Visits, and Walk-in Center Visits. The first office visit will accumulate across medical benefits.</p> <p>A copayment will be applied to all subsequent office visits during the plan year.</p>	<p>In-Person Visits: 20% Coinsurance</p> <p>Virtual Visits: 20% Coinsurance</p>	<p>40% Coinsurance</p>
<ul style="list-style-type: none"> Mental Health and Substance Use Disorder Provider (Including In-Person and/or Virtual Visits) <p>Note: There is no charge for the first In-Network behavioral health office visit in each plan year. Subsequent visits will apply the PCP copayment. The first office visit cross accumulates across Mental Health and Substance Use Disorder benefits.</p> <ul style="list-style-type: none"> Specialty Care Physician / Provider (SCP) (including In-Person and/or Virtual Visits) 	<p>In-Person Visits: 20% Coinsurance</p> <p>Virtual Visits: 20% Coinsurance</p> <p>In-Person Visits: 20% Coinsurance</p> <p>Virtual Visits: 20% Coinsurance</p>	<p>40% Coinsurance</p> <p>40% Coinsurance</p>
<ul style="list-style-type: none"> Retail Health Clinic Visit 	<p>20% Coinsurance</p>	<p>40% Coinsurance</p>
<ul style="list-style-type: none"> Counseling (includes Family Planning and Nutritional Counseling – other than for eating disorders) 	<p>20% Coinsurance</p>	<p>40% Coinsurance</p>

<ul style="list-style-type: none"> Nutritional Counseling (for eating disorders) <p>Note: There is no charge for the first In-Network behavioral health office visit in each plan year. Subsequent visits will apply the PCP copayment. The first office visit cross accumulates across Mental Health and Substance Use Disorder benefits.</p>	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Allergy Testing 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Shots / Injections (other than allergy serum) 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Allergy Shots / Injections (including allergy serum) 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Diagnostic Lab (other than reference labs) 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Diagnostic X-ray (non-preventive) 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Other Diagnostic Tests (including hearing and EKG) 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Advanced Diagnostic Imaging (including MRIs, CAT scans) 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Office Surgery (including anesthesia) 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Therapy Services: 		
<ul style="list-style-type: none"> - Chiropractic /Osteopathic / Manipulative Therapy 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> - Physical Therapy 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> - Speech Therapy 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> - Occupational Therapy 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> - Dialysis / Hemodialysis 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> - Radiation / Chemotherapy / Respiratory Therapy 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> - Cardiac Rehabilitation (Phases I & II) 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> - Pulmonary Therapy 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> - Acupuncture 	20% Coinsurance	40% Coinsurance
See "Therapy Services" for details on Benefit Maximums.		
<ul style="list-style-type: none"> Prescription Drugs Administered in the Office (other than allergy serum) 	20% Coinsurance	40% Coinsurance

Orthotics	See "Durable Medical Equipment (DME), Medical Devices, and Supplies."	
Outpatient Facility Services (including Freestanding Imaging Centers and Independent Laboratories)		
• Facility Surgery Charge	20% Coinsurance	40% Coinsurance
• Facility Surgery Lab	20% Coinsurance	40% Coinsurance
• Facility Surgery X-ray	20% Coinsurance	40% Coinsurance
• Ancillary Services	20% Coinsurance	40% Coinsurance
• Doctor Surgery Charges	20% Coinsurance	40% Coinsurance
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	20% Coinsurance	40% Coinsurance
• Other Facility Charges (for procedure rooms)	20% Coinsurance	40% Coinsurance
• Mental Health / Substance Use Disorder Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance	40% Coinsurance
• Mental Health / Substance Use Disorder Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance	40% Coinsurance
• Shots / Injections (other than allergy serum)	20% Coinsurance	40% Coinsurance
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance	40% Coinsurance
• Diagnostic Lab	20% Coinsurance	40% Coinsurance
• Diagnostic X-ray	20% Coinsurance	40% Coinsurance
• Other Diagnostic Tests: EKG, EEG, etc.	20% Coinsurance	40% Coinsurance
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	40% Coinsurance
• Other (blood administration, removal of sutures or cast, removal of impacted or unerupted teeth, endoscopic procedures)	20% Coinsurance	40% Coinsurance

• Therapy:		
- Chiropractic /Osteopathic / Manipulative Therapy	20% Coinsurance	40% Coinsurance
- Physical Therapy	20% Coinsurance	40% Coinsurance
- Speech Therapy	20% Coinsurance	40% Coinsurance
- Occupational Therapy	20% Coinsurance	40% Coinsurance
- Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance	40% Coinsurance
- Dialysis / Hemodialysis	20% Coinsurance	40% Coinsurance
- Cardiac Rehabilitation (Phases I & II)	20% Coinsurance	40% Coinsurance
- Pulmonary Therapy	20% Coinsurance	40% Coinsurance
See "Therapy Services" for details on Benefit Maximums.		
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	20% Coinsurance	40% Coinsurance
Outpatient Facility Services – Site of Service Ambulatory Surgery and Radiology Centers		
• Ambulatory Surgery Center – Facility Surgery	20% Coinsurance	40% Coinsurance
• Ambulatory Surgery Center – Surgery Lab	20% Coinsurance	40% Coinsurance
• Ambulatory Surgery Center – Surgery X-ray	20% Coinsurance	40% Coinsurance
• Ambulatory Surgery Center – Ancillary Services	20% Coinsurance	40% Coinsurance
• Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgery, Surgical Assistant)	20% Coinsurance	40% Coinsurance
• Radiology Center – Diagnostic X-ray	20% Coinsurance	40% Coinsurance
• Radiology Center – Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	40% Coinsurance
Physical Therapy	See "Therapy Services."	

<p>Preventive Care (including, but not limited to, colorectal screening, prostate cancer screening, mammogram, pap test, annual gynecological exam)</p> <p>Note: You may incur additional cost shares when services other than Preventive Care are rendered during a Preventive Care visit. Benefits will be based on the service code billed by your Provider For example, non-preventive x-rays or diagnostic tests performed during a preventive visit could be billed separately and may have a cost share.</p>	<p>No Copayment, Deductible, or Coinsurance</p>	<p>40% Coinsurance</p>
<p>Preventive Care for Chronic Conditions (per IRS guidelines)</p> <ul style="list-style-type: none"> • Prescription Drugs • Medical items, equipment and screenings <p>Please see the “What’s Covered” section for additional detail on IRS guidelines.</p>		
<p>Prosthetics</p>	<p>See “Durable Medical Equipment (DME) Medical Devices and Supplies.”</p>	
<p>Pulmonary Therapy</p>	<p>See “Therapy Services.”</p>	
<p>Radiation Therapy</p>	<p>See “Therapy Services.”</p>	
<p>Rehabilitation Services (including for head injuries)</p>	<p>Benefits are based on the setting in which Covered Services are received.</p>	
<p>Respiratory Therapy</p>	<p>See “Therapy Services.”</p>	
<p>Skilled Nursing Facility</p>	<p>See “Inpatient Services.”</p>	
<p>Speech Therapy</p>	<p>See “Therapy Services.”</p>	
<p>Surgery (including, but not limited to, breast reduction surgery, symptomatic varicose vein surgery and bariatric surgery)</p>	<p>Benefits are based on the setting in which Covered Services are received.</p>	
<p></p>	<p></p>	<p></p>
<p style="text-align: center;">Benefits</p>	<p style="text-align: center;">In-Network</p>	<p style="text-align: center;">Out-of-Network</p>
<p>Temporomandibular and Craniomandibular Joint Treatment</p>	<p>Benefits are based on the setting in which Covered Services are received.</p>	

<p>Therapy Services (including but not limited to inpatient and outpatient Infusion therapy, Inhalation Therapy and Massage Therapy)</p> <p>Benefit Maximum(s):</p> <ul style="list-style-type: none"> • Physical, Occupational & Speech Therapy • Manipulation Therapy • Cardiac Rehabilitation • Pulmonary Rehabilitation • Acupuncture 	<p>Benefits are based on the setting in which Covered Services are received.</p> <p>Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.</p> <p>30 visits per Benefit Period</p> <p>40 visits per Benefit Period</p> <p>36 visits per Benefit Period</p> <p>Unlimited</p> <p>30 visits per Benefit Period</p>
<p>Note: The limits for physical, occupational, and speech therapy will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.</p> <p>Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice or Autism benefit.</p> <p>Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Health Care Visit limit will apply instead of the Therapy Services limits listed above.</p>	
<p>Transplant Services</p>	<p>See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."</p>
<p>Urgent Care Services / Walk-In Center (Office & Home* Visits)</p>	
<p>* Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.</p>	
<ul style="list-style-type: none"> • Urgent Care Visit Charge 	<p>20% Coinsurance</p> <p>40% Coinsurance</p>
<ul style="list-style-type: none"> • Allergy Testing 	<p>20% Coinsurance</p> <p>40% Coinsurance</p>
<ul style="list-style-type: none"> • Shots / Injections (other than allergy serum) 	<p>20% Coinsurance</p> <p>40% Coinsurance</p>
<ul style="list-style-type: none"> • Allergy Shots / Injections (including allergy serum) 	<p>20% Coinsurance</p> <p>40% Coinsurance</p>
<ul style="list-style-type: none"> • Diagnostic Labs (other than reference labs) 	<p>20% Coinsurance</p> <p>40% Coinsurance</p>
<ul style="list-style-type: none"> • Diagnostic X-ray 	<p>20% Coinsurance</p> <p>40% Coinsurance</p>
<ul style="list-style-type: none"> • Other Diagnostic Tests (including hearing and EKG) 	<p>20% Coinsurance</p> <p>40% Coinsurance</p>

<ul style="list-style-type: none"> Advanced Diagnostic Imaging (including MRIs, CAT scans) 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Office Surgery (including anesthesia) 	20% Coinsurance	40% Coinsurance
<ul style="list-style-type: none"> Prescription Drugs Administered in the Office (includes allergy serum) 	20% Coinsurance	40% Coinsurance
<p>If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.</p>		
<p>Virtual Visits (from Virtual Care Only Providers)</p>		
	Virtual Visits Conducted through our mobile app and website:	Other Virtual Visits:
<ul style="list-style-type: none"> Virtual Visits including Primary Care from Virtual Care-Only Providers (Medical Services) <p>Please note: There is no member cost share In-Network for the first primary care office visit in each plan year. First primary care visit includes Primary Care In-Person and/or Virtual Visits, Telemedicine/Telehealth, Retail Health Clinic Visits, and Walk-in Center Visits. The first office visit will accumulate across medical benefits.</p> <p>A copayment will be applied to all subsequent office visits in each plan year.</p>	No Copayment, Deductible, or Coinsurance	Please refer to the “Office and Home Visits” section.
<ul style="list-style-type: none"> Virtual Visits from Virtual Care-Only Providers (Mental Health and Substance Use Disorder Services) 	No Copayment, Deductible, or Coinsurance	Please refer to the “Office and Home Visits” section.
<ul style="list-style-type: none"> Virtual Visits from Virtual Care-Only Providers (Specialty Care Services) 	No Copayment, Deductible, or Coinsurance	Please refer to the “Office and Home Visits” section.
<p>If Preventive Care is provided during a Virtual Visit, it will be covered under the “Preventive Care” benefit, as required by law. Please refer to that section for details.</p>		

	In Network	Out-of-Network
<p>Vision Services Members through Age 18</p> <p>To receive the In-Network benefit, you must use a Blue View Vision provider. Visit our website or call the number on your ID card for help in finding a Blue View Vision provider.</p> <p>Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.</p>		
<p>Routine Eye Exam (Once every calendar year)</p>	\$0 Copayment	\$0 Copayment up to Maximum Allowed Amount
<p>Standard Plastic Lenses Limited to one set of lenses per calendar year per member.</p> <ul style="list-style-type: none"> • Single Vision • Bifocal • Trifocal <p>Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received from In-Network Providers.</p>	<p>\$0 Copayment</p> <p>\$0 Copayment</p> <p>\$0 Copayment</p>	<p>\$0 Copayment up to Maximum Allowed Amount</p> <p>\$0 Copayment up to Maximum Allowed Amount</p> <p>\$0 Copayment up to Maximum Allowed Amount</p>
<p>Frames Limited to one frame from the Anthem Formulary per calendar year per member.</p>	\$0 Copayment	\$0 Copayment up to Maximum Allowed Amount
<p>Contact Lenses Elective or non-elective contact lenses from the Anthem formulary are covered once per calendar year per member.</p> <p>Elective Contact Lenses</p> <p>Non-Elective Contact Lenses</p> <p>Important Note: Benefits for contact lenses are in lieu of your eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglasses until the next benefit period.</p>	<p>\$0 Copayment</p> <p>\$0 Copayment</p>	<p>\$0 Copayment up to Maximum Allowed Amount</p> <p>\$0 Copayment up to Maximum Allowed Amount</p>

Comprehensive low vision exam Limited to one per calendar year	\$0 Copayment	Not Covered
	In Network	Out-of-Network
Optical/Non-optical aids/Supplemental Testing Limited to one occurrence of either optical/non-optical aids or supplemental testing per calendar year.	\$0 Copayment	Not Covered
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye)		
Benefits are based on the setting in which Covered Services are received. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		

Prescription Drug Retail Pharmacy Benefits	In-Network	Out-of-Network
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		

Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Note: For FDA-approved Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.		
<ul style="list-style-type: none"> Retail Pharmacy (In-Network and Out-of-Network) 	30 days Note: A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply. When you get a 30-day supply, one Copayment per Prescription Order will apply.	
<ul style="list-style-type: none"> Specialty Pharmacy 	30* *See additional information in the "Specialty Drug Copayments / Coinsurance" section below.	

Note: Prescription Drugs that we are required to cover by federal law under the “Preventive Care” benefit will be covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

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

Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	\$10 Copayment per Prescription Drug	40% Coinsurance per Prescription Drug
Tier 2 Prescription Drugs	\$30 Copayment per Prescription Drug	40% Coinsurance per Prescription Drug
Tier 3 Prescription Drugs	\$50 Copayment per Prescription Drug	40% Coinsurance per Prescription Drug
<p>Note: You may also obtain up to a 90-day supply of maintenance medications at certain Maine retail pharmacies. You can learn whether your pharmacy participates in the Mail Service Prescription Drug Program by calling the Member Services Department at the number on your ID Card. A list of pharmacies participating in the program is also available online at www.anthem.com.</p>		

Specialty Drug Copayments / Coinsurance:
<p>Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy. Please see “Specialty Pharmacy” in the section “Prescription Drug Benefit at a Retail Pharmacy” for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments / Coinsurance you pay for a 30-day supply at a Retail Pharmacy.</p>
<p>Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy.</p>

How Your Plan Works

Introduction

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

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

In-Network Services

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

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

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We will determine the Medical Necessity of the service. Our determination will be based on our definition of Medically Necessary Health Care.

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

To see a Doctor, call their office:

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

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

For services from In-Network Providers:

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

After Hours Care

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

Out-of-Network Services

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

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments unless your claim involves a Surprise Billing Claim;
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments) unless your claim involves a Surprise Billing Claim;
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and

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

Surprise Billing Claims

Surprise Billing Claims are described in the "Surprise Billing Protection Notices" at the beginning of this Booklet. Please refer to that section for further details.

Connect with Us Using Our Mobile App

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

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

How to Find a Provider in the Network

There are several ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Search for a Provider in our mobile app.
- Contact Member Services to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area. Member Services can help you determine the Provider's name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.
- Check with your Doctor or Provider.

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.

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

Continuity of Care

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

- 1) In treatment for a serious and complex condition. This can be a sudden (acute) illness that requires specialized treatment to avoid death or permanent harm.
- 2) In a hospital or other inpatient facility.
- 3) Scheduled for nonelective surgery by your current doctor, including your post-operative care for the surgery.
- 4) Pregnant (including postpartum care).
- 5) Terminally ill.

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

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

Your Cost-Shares

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

The BlueCard Program

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

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

Identification Card

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

Getting Approval for Benefits

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

Reviewing Where Services Are Provided

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

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

Certain services must be reviewed to determine Medical Necessity in order for you to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a service that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members, will give you similar results for a disease or condition.

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

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

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

Types of Reviews

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

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

For admissions following Emergency Care, you, your authorized representative or Doctor must tell us of the admission as soon as possible. For childbirth admissions, Precertification is not needed unless

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

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

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

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

Who is Responsible for Precertification?

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

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	<ul style="list-style-type: none"> • The Provider must get Precertification when required.
Out of Network / Non-Participating	Member	<ul style="list-style-type: none"> • Member must get Precertification when required (Call Member Services). • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.

BlueCard Provider	Member (Except for Inpatient Admissions)	<ul style="list-style-type: none"> • 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.
<p>Note: For an Emergency Care admissions, precertification is not required. However, you, your authorized representative or Doctor must tell us of the admission as soon as possible.</p>		

How Decisions are Made

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section “Prescriptions Drugs Administered by a Medical Provider”. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

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

If you are not satisfied with our decision under this section of your benefits, please refer to the “Complaints and Appeals” section to see what rights may be available to you.

Decision and Notice Requirements

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

Type of Review	Timeframe Requirement for Decision
Urgent Pre-service Review	24 hours from the receipt of request
Non-Urgent Pre-service Review	72 hours or 2 business days from the receipt of the request, whichever is less.
Urgent Concurrent Review Review for ongoing inpatient stay or outpatient treatment	24 hours from the receipt of the request
Concurrent Review Review for ongoing inpatient stay or outpatient treatment	1 working day after obtaining all necessary information
Post-Service Review	30 calendar days after obtaining all necessary information

If more information is needed to make our decision, we will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If we do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, we will make a decision based upon the information we have.

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

Important Information

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

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

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

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by checking your on-line Provider Directory or contacting the Member Services number on the back of your ID card.

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

Health Plan Individual Case Management

Our Health Plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions, including but not limited to Asthma, Heart Disease, Depression, Diabetes, High Blood Pressure & High Cholesterol, Low Back Pain and Pain. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

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

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

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

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

What's Covered

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

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

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

Acupuncture

Please see "Therapy Services" later in this section.

Allergy Services

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

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

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

And one or more of the following criteria are met.

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

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

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, the Out-of-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

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

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

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.**

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

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

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

Asthma Education

Benefits are provided for approved asthma education programs for our covered Members with asthma and their families. Benefits are provided when the program is received from an approved Network Provider.

Autism Spectrum Disorders

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

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

Bedside Visits

International Students and Domestic Students Traveling Abroad, when you are Hospital Confined for more than 7 continuous days as the result of a covered injury or covered sickness, We will pay a benefit. We will pay for the cost of an economy round-trip airfare for an individual to travel to your Hospital bedside. The benefit will not exceed the amount shown in the Schedule of Benefits. This individual must be designated by you, and the trip must be approved by us. No more than one trip may be made during any one policy year.

Behavioral Health Services

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

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products.

Blood Transfusions

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

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Cellular and Gene Therapy Services

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

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

Approved In-Network Provider

A Provider who has entered into an agreement with us to provide Covered Services to you. The agreement may only cover certain Covered Services or all Covered Services. Approved In-Network Providers may include the following:

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

All Other Providers

Any Provider that is Not an Approved In-Network Provider. This includes In-Network Providers who participate in the Plan's networks, but who are not an Approved In-Network Provider for certain cellular or gene therapy services, as well Out-of-Network Providers.

Transportation and Lodging Assistance

If you will need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Services will be provided, we will cover the cost of reasonable and necessary travel costs when you get prior approval. Please see the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell)" benefit for further details on travel coverage, and limits.

Services Not Eligible for Coverage

Your Plan does not include benefits for the following;

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

Chemotherapy

Please see "Therapy Services" later in this section.

Chiropractic Services

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

Clinical Trials

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

An enrollee is eligible for coverage for participation in an approved clinical trial if the enrollee meets the following conditions:

- a. The enrollee has a life-threatening illness for which no standard treatment is effective;
- b. The enrollee is eligible to participate according to the clinical trial protocol with respect to treatment of such illness
- c. The enrollee's participation in the trial offers meaningful potential for significant clinical benefit to the enrollee; and
- d. The enrollee's referring physician has concluded that the enrollee's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs a, b and c.

Benefits are limited to the following trials:

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

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

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

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

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

COVID-19 Diagnosis and Prevention

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

Dental Procedures

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

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

Dental Services for Cancer Patients

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

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

Routine preventive dental care, including cleaning and sealants, are not Covered Services

Dental Services

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

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

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

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

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

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

Pediatric Dental Covered Services

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

Diagnostic and Preventive Services

Oral Exams. Covered 2 times per 12 months.

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

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

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

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

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

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

Space Maintainers and Recement Space Maintainers.

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

Basic Restorative Services

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

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

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

for the difference, if the dentist charges more, plus any applicable deductible or coinsurance.

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

Endodontic Therapy on Primary Teeth

- Pulpal therapy
- Therapeutic pulpotomy

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

Resin Based Crown

Partial Pulpotomy for Apexogenesis. Covered on permanent teeth only.

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

Pin Retention

Therapeutic Drug Injection

Basic Tooth Extractions.

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

Surgical Incision and Drainage of an Abscess.

Endodontic Services

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

- Root canal therapy.
- Root canal retreatment.

Other Endodontic Treatments

- Apexification
- Apicoectomy
- Root amputation
- Hemisection

Periodontal Services

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

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

- Gingivectomy/gingivoplasty
- Gingival flap
- Apically positioned flap

- Osseous surgery
- Bone replacement graft

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

- Pedicle soft tissue graft.
- Free soft tissue graft
- Subepithelial connective tissue graft.
- Soft tissue allograft

Crown Lengthening.

Oral Surgery Services

Basic Extractions

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

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

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

Other Complex Surgical Procedures

- Alveoplasty
- Removal of exostosis – per site

Other Oral Surgery Procedures.

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

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

Major Restorative Services

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

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

Onlays or Permanent Crowns. Covered 1 time per 60 months. Only covered on a permanent tooth. To be covered, the tooth must have extensive loss of natural structure due to decay or fracture so that

another restoration (such as a filling or inlay) cannot be used to restore the tooth. We will pay up to the maximum allowed amount for a porcelain to noble metal crown. If you choose to have another type of crown, you're responsible to pay for the difference plus any applicable deductible and coinsurance.

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

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

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

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

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

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

Prosthodontic Services

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

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

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

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

Tissue Conditioning.

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

Repairs and Replacement of Broken Clasps.

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

Denture Adjustments.

Partial and Bridge Adjustments.

Recementation of Bridge (fixed prosthetic).

Single Tooth Implant Body, Abutment and Crown. Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown. Some adjunctive implant services may not be covered. It's recommended that you get a pretreatment estimate, so you fully understand the treatment and cost before having implant services done.

Orthodontic Care

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

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

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

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

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

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

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

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

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

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

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

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

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

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

Treatment of Accidental Injury

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

Diabetes Equipment, Education, and Supplies

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

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

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

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

Dialysis

Please see “Therapy Services” later in this section.

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

Durable Medical Equipment and Medical Devices

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

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

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

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

Oxygen and equipment for its administration are also Covered Services.

Hearing Aids

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

Orthotics

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

Prosthetics

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

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

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

Medical and Surgical Supplies

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

Early Intervention Services

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

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

Emergency Care Services

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

Emergency Medical Condition

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

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

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

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

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

Emergency Care

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

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

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as you are stabilized. Emergency Care may also include necessary services, including observation services provided as part of the Emergency visit regardless of the department in which services are provided. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details.

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

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

Foot Care

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

Fertility Services

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

Habilitative Services

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

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

Home Health Care Services

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

Covered Services include but are not limited to:

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

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

Home Infusion Therapy

Please see “Therapy Services” later in this section.

Hospice Care

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

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

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

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

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

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

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

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

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

Covered Transplant Procedure

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

Prior Approval and Precertification

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

must call our Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

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

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

Donor Benefits

Benefits for an organ donor are as follows:

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

Transportation and Lodging

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

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

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

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,
- Laundry,
- Postage,

- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Coverage for the cost of testing for bone marrow donation suitability

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

- A. The covered member must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;
- B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a;
- C. At the time of the testing, the covered member must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found.

This benefit is limited to one test per lifetime.

Inborn Error of Metabolism

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

Infant Formula

The Plan provides Benefits for amino acid-based elemental infant formula for children 2 years of age and under when a covered Provider has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. A covered Provider may be required to confirm and document ongoing medical necessity at least annually.

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

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

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

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

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

Maternity and Reproductive Health Services

Maternity Services

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

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed midwife;

- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services;
- Postpartum services that are necessary to transition a Member to a healthy and stable condition that meets the recommendations of the American College of Obstetricians and Gynecologists as outlined in the opinion entitled "Optimizing Postpartum Care" published May 2018 will be covered for up to 12 months following the end of the pregnancy; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

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

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

Donor Breast Milk

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

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

Contraceptive Benefits

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

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

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

Sterilization Services

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

Abortion Services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Provider, performed to save the life or health of the mother. The Plan will also cover elective abortions except as prohibited by law. Services will be provided without cost-sharing when you use an In-Network Provider.

Fertility Services

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

Medically Necessary Covered Services will include:

- Artificial insemination, with intrauterine insemination limited to three lifetime cycles
- Assisted hatching
- Diagnosis and diagnostic tests as described above
- Up to four completed egg retrievals per lifetime of the egg retrieval patient, provided that
- Where a live donor is used in an egg retrieval, the medical costs of the donor associated with the retrieval will be covered until the donor is released from treatment by the reproductive endocrinologist; donor medical costs include without limitation physical examination, laboratory screening, psychological screening, and Prescription Drugs;
- Egg retrievals where the cost was not covered by any carrier, self-insured health plan, or governmental program will not count toward the four completed egg retrieval limit.
- Up to two lifetime cycles of any combination of fresh or frozen embryo transfer (FET), in vitro fertilization (IVF), gamete intrafallopian tube transfer (GIFT), or zygote intrafallopian transfer (ZIFT)
 - No coverage for IVF, GIFT or ZIFT until all reasonable less expensive and medically appropriate treatments for Infertility have been attempted
- Intracytoplasmic sperm injections
- Medications, including injectable infertility medications
- Ovulation induction
- Surgery, including microsurgical sperm aspiration
- Costs associated with Cryopreservation and storage of sperm, eggs and embryos for an individual who has a medical or genetic condition or who is expected to undergo treatment that may directly or indirectly cause a risk of impairment of fertility.

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

Mental Health and Substance Use Disorder Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
 - Observation and assessment by a physician weekly or more often,
 - Rehabilitation and therapy.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs and (when available in your area) Intensive In-Home Behavioral Health Services.
- **Virtual Visits** as described under the “Virtual Visits (Telemedicine / Telehealth Visits)” section.

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

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C),
- Licensed Pastoral Counselor or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Non-Emergency Care Outside of the United States

We provide Benefits for Inpatient and Outpatient services in a foreign Hospital. If you obtain Covered Services outside of the United States, in most cases you will have to pay your bill when you leave the Hospital.

When you return home, send the following to us with your claim form:

- A statement of the nature of the illness or injury;
- An itemized statement translated into English (accompanied by the original statement) showing the services received and the date(s) of service;
- Your Contract number; and
- The dollar rate of exchange at the time you received the service(s), if possible.

When we receive this information, we will reimburse you for Covered Services according to the terms of this Contract.

Nutritional Counseling

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

Occupational Therapy

Please see “Therapy Services” later in this section.

Office and Home Visits

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury. You may not be required to obtain a second opinion from a Provider that practices in the same office location as the first Provider. If the second opinion is obtained from a Non-Network Provider because a Network Provider is not available in network, we may not apply a deductible, coinsurance or copayment for the second opinion in an amount greater than the deductible, coinsurance or copayment that would apply to the same Covered Service if the Covered Service were obtained from a Network Provider.

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

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

Retail Health Clinic Care for limited basic health care services to Members without an appointment. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

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

Urgent Care Services as described in “Urgent Care Services” later in this section.

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

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

Orthotics

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

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

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

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

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive and Well Care

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

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the “Diagnostic Services” benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services. Services related to a specific health concern, condition or injury may be separately billed as an office visit and may be subject to cost-sharing requirements as provided in the health plan.

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - a. Breast cancer (screening mammogram, diagnostic breast exam and supplemental breast exams will be covered without any cost-sharing when services are provided by an In-Network Provider),
 - b. Cervical cancer (pap test),
 - c. Colorectal cancer - This includes the preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. It also includes preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e. flexible sigmoidoscopy, CT colonography),
 - d. High blood pressure,
 - e. Type 2 Diabetes Mellitus,
 - f. Cholesterol,
 - g. Child and adult obesity.

Note: Coverage is provided for colorectal cancer screening for asymptomatic individuals at risk for colorectal cancer.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - Women’s contraceptives, sterilization treatments, and counseling. This includes Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Some categories and classes of contraceptives do not have Generics available and, in each of these categories, at least one Brand Drug is available at \$0 cost sharing when you receive it from an In-Network Provider. If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent is Medically Necessary because a Generic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Drug with \$0 cost-sharing if your Provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. You or your Doctor can find the form online at https://file.anthem.com/Anthem_ABS_BrandContraceptiveCopayWaiverForm.pdf or by calling the number listed on the back of your ID Card. If Medical Necessity has been

determined by your Provider, an exception will be granted and coverage of the Drug will be provided at \$0 cost sharing. Otherwise, Brand Drugs will be covered under the Prescription Drug Benefit at a Retail Pharmacy section.”

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

- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to 1 pump per pregnancy.
- Gestational diabetes screening.

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

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

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

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

Preventive Care for Chronic Conditions (per IRS Guidelines)

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

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

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

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

Prostate Specific Antigen

Your Plan covers Prostate Specific Antigen test and digital rectal examination for men.

Prosthetics

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

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

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

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

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

We do not require prior authorization for the first 12 visits of each new episode of Medically Necessary care.

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

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Smoking Cessation

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

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

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

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

Breast Reduction Surgery

The Plan provides benefits for medically necessary breast reduction surgery.

Oral Surgery

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

Benefits are limited to certain oral surgeries including:

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

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

Reconstructive Surgery

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

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

Mastectomy Notice

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

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

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

Varicose Vein Surgery

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

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments. Please see the "Chiropractic Services" provision earlier in this section for additional information.
- **Massage Therapy** – When services are part of an active course of treatment and the services are performed by a Covered Provider. A massage therapist is not a covered provider.
- **Acupuncture** – Treatment of neuromusculoskeletal pain by an acupuncturist who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details. Benefits are also available for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications.

- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). Also covers Prescription Drugs when they are administered to you as part of a Doctor’s visit, home care visit or at an Outpatient Facility. See the section “Prescription Drugs Administered by a Medical Provider” for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive Rehabilitation Therapy** –Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory/Inhalation Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; water vapor; therapeutic use of medical gases (including carbon dioxide, helium) or Drugs (including anesthetics) in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

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

Urgent Care Services

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

Benefits for urgent care include:

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

Virtual Visits (Telemedicine / Telehealth Visits)

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

- “Telemedicine / Telehealth” means the delivery of health care or other health services using electronic communications and information technology, including: live (synchronous) secure

videoconferencing or secure instant messaging, interactive store and forward (asynchronous) technology, telemonitoring, and audio-only.

Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

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

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

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

Vision Services

Pediatric

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

Routine Eye Exam

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

Eyeglass Lenses

Standard plastic (CR39) eyeglass lenses up to 55mm are covered, whether they are single vision, bifocal, trifocal (FT 25-28), progressive or lenticular.

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

Frames

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

Contact Lenses

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

- **Elective contact lenses** are ones you choose for comfort or appearance.
- **Non-elective contact lenses** are ones prescribed for certain eye conditions:
 - Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses
 - High ametropia exceeding -12D or +9D in spherical equivalent
 - Anisometropia of 3D or more
 - For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

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

Low Vision

Low vision is when you have a significant loss of vision, but not total blindness. Your plan covers services for this condition when you go to a Blue View Vision eye care provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

Prescription Drugs Administered by a Medical Provider

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

Important Details About Prescription Drug Coverage

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

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

- Quantity, dose, and frequency of administration
- Specific clinical criteria including, but not limited to, requirements regarding age (based on FDA labeling), test result requirements, and/or presence of a specific condition or disease.
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies).
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated.
- Use of an Anthem Prescription Drug List (a formulary developed by us) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Covered Prescription Drugs

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

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

Precertification

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

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

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

If precertification is denied you have the right to file an appeal as outlined in the Complaints and Appeals” section of this Booklet.

Designated Pharmacy Provider

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

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

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

If You are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, you will not have coverage for that Prescription Drug.

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

Continuity of Prescription Drugs

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

Therapeutic Equivalents

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

Prescription Drug Benefit at a Retail Pharmacy

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

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

Prescription Drug Benefits

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

Prior Authorization

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

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

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

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

Anthem may, from time to time, waive enhance, change or end certain prior authorization and/or offer alternate benefits, if such change furthers the provision of cost effective, value based and/or quality services.

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

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Drugs from a Retail Pharmacy ;
- Specialty Drugs;
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Continuous glucose monitoring systems. Note: Each component of the monitoring system will be subject to a separate Copayment/Coinsurance.
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Coverage is also provided for up to a 12-month supply of FDA-approved contraceptives when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for information.
- Oral Chemotherapy
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary.
- Flu Shots (including administration) these will be covered under the "Preventive Care" benefit.
- Immunizations required by the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older.
- Compound ingredients within a compound drug when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- At least one FDA-approved HIV prevention drug for each method of administration with no member cost share.

Where You Can Get Prescription Drugs

In-Network Pharmacy

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

Preferred retail pharmacies may fill your Prescription at the same cost shares that apply to the home delivery pharmacy level of benefits. Please ask your pharmacy if they offer this special arrangement or call Pharmacy Member Services at the phone number on your ID Card.

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

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

Out-of-Network Pharmacy

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

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

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

Maintenance Pharmacy

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

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time. We may require you or your doctor to order certain Specialty Drugs from a Specialty Pharmacy.

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

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

What You Pay for Prescription Drugs

Tiers

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

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

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier. We will provide at least 30 days prior written notice of any modification to a formulary that results in the movement of a Prescription Drug to a tier with higher cost-sharing requirements.

Abuse-deterrent opioid analgesic Drugs are available on a basis not less favorable than that for opioid analgesic Drugs that are not abuse-deterrent. This means that your cost share may be lower for certain abuse-deterrent opioid analgesic Drugs. For additional information, please call the Pharmacy Member Services number on your ID card.

Prescription Drug List

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

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

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

You may request a copy of the Covered Prescription Drug list by calling the Members Services telephone number on the back of your Identification Card or by visiting our website at www.anthem.com. The covered Prescription Drug List is subject to periodic review and amendment. Inclusion of a drug or related item on the covered Prescription Drug list is not a guarantee of coverage. Unless a Drug is being removed from the formulary due to safety concerns, we will provide 60 days written notice of an adverse change to the formulary to Members who are currently taking the Prescription Drug. An adverse change to the formulary includes the removal of a Prescription Drug from the formulary. It also includes moving the Prescription Drug to a higher cost share tier when such decision is not a result of the introduction to the market of a generic equivalent of that Prescription Drug.

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

If you or your Doctor believes you need a Prescription Drug that is not on the Prescription Drug List, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the other Drugs that are on the List. We will make a coverage decision within 72 hours or 2 business days, whichever is less, of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills. If we deny coverage of the Drug, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision with 72 hours or 2 business days, whichever is less, of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills.

You or your Doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the Plan.

We will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If we deny coverage of the Drug you have the right to request and external review by an IRO. The IRO will make a coverage decisions within 24 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency.

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

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits." In most cases, you must use a certain amount of your prescription before it can be refilled. In some cases we may let you get an early refill. For example, we may let you refill your prescription early if it is decided that you need a larger dose. As required by Maine law, one early refill for prescription eye drops may be available. We may also authorize coverage for less than a 30-day supply for purposes of synchronizing medications. We will work with the Pharmacy to decide when this should happen.

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

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

Therapeutic Equivalents

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

Split Fill Dispensing Program

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

Drug Cost Share Assistance Programs

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

Special Programs

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

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

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

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

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

What's Not Covered

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

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

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

1) **Administrative Charges**

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

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

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

- Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.
- Holistic medicine,
- Homeopathic medicine,
- Hypnosis,
- Aroma therapy,
- Massage and massage therapy, except for massage therapy services that are part of a physical therapy treatment plan and covered under the "Therapy Services" section of this Booklet,
- Reiki therapy,
- Herbal, vitamin or dietary products or therapies,
- Naturopathy (services provided by a naturopath are not covered if they would not be covered by other Plan Providers),
- Thermography,
- Orthomolecular therapy,
- Contact reflex analysis,
- Bioenergetic synchronization technique (BEST),
- Iridology-study of the iris,
- Neurofeedback / Biofeedback.

4) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) for all indications except as described under Autism Services in the "What's Covered" section unless otherwise required by law.

- 5) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

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

- 6) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers
- 7) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.
- 8) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims as outlined in the “Consolidated Appropriations Act of 2021 Notice” in the front of this Booklet.
- 9) **Chats or Texts** Chats and texting are not a Covered Service unless appropriately provided via a secure and compliant application, according to applicable legal requirements.
- 10) **Clinical Trial Non-Covered Services** Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- 11) **Clinically Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com. If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.
- 12) **Complications of/or Services Related to Non-Covered Services** Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
- 13) **Compound Ingredients** Compound ingredients that are not FDA-approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- 14) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin (i.e. acne or dermatological services) 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.

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

- 16) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- 17) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- 18) **Delivery Charges** Charges for delivery of Prescription Drugs.
- 19) **Dental Devices for Snoring** Oral appliances for snoring.
- 20) **Dental Services** Coverage is not provided for the following Dental-related services:
- Dental care for members age 19 and older, unless covered by the medical benefits of this Plan.
 - Dental services or health care services not specifically covered under the Plan (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).
 - Oral hygiene instruction, including guidance regarding home care. Some examples of oral hygiene instructions include instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.
 - Case presentations of detailed treatment plans, office visits during and after regularly scheduled hours, when no other services are performed.
 - Services of anesthesiologist, unless required by law.
 - Anesthesia services, (such as intravenous or non-intravenous conscious sedation, analgesia, nitrous oxide, and general anesthesia) are not covered when given separate from a covered oral surgery service, except as required by law.
 - Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
 - Dental services provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
 - Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
 - Enamel microabrasion and odontoplasty.
 - Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Plan.
 - Biological tests for determination of periodontal disease or pathologic agents, unless covered by the medical benefits of this Plan.
 - Collection of oral cytology samples via scraping of the oral mucosa, unless covered by the medical benefits of this policy.
 - Separate services billed when they are an inherent component of another covered service.
 - Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
 - Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
 - Provisional splinting temporary procedures or interim stabilization.
 - Pulp vitality tests
 - Adjunctive diagnostic tests
 - Incomplete root canals
 - Cone beam images
 - Anatomical crown exposure
 - Temporary anchorage devices
 - Sinus augmentation.
 - Oral hygiene instructions.
 - Repair or replacement of lost or broken appliances.

- Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
 - Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
 - The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
 - For dental services received prior to the effective date of this Plan or received after the coverage under this Plan has ended.
 - Dental services given by someone other than a licensed provider (dentist or physician) or their employees.
 - Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this Plan.
 - Athletic mouth guards.
 - Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.
 - For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.
- 21) **Dental treatment** for injuries that are a result of biting or chewing, unless the chewing or biting results from a medical or mental condition. This Exclusion does not apply to services that we must cover by law.
- 22) **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- 23) **Drugs Over Quantity or Age Limits** Drugs in quantities which are over the limits set by the Plan, or which are over any age limits based on FDA labeling.
- 24) **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- 25) **Drugs Prescribed by Providers Lacking Qualifications/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications including certifications, as determined by Anthem.
- 26) **Drugs that Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section. This exclusion does not apply to over-the-counter drugs that we must cover under Federal law when recommended by the U.S. Preventive Services Task Force and are prescribed by a physician (contraceptives). For additional information, please refer to the United States Preventive Services Task Force website: www.uspreventiveservicestaskforce.org.
- 27) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
- 28) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

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

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

- 43) **Hospital Services Billed Separately** Services by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
- 44) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
- 45) **Infertility Treatment** Infertility procedures not specified in this Booklet.
- 46) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
- 47) **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This exclusion does not apply to “Habillitative Services” as described in the “What’s Covered” section.
- 48) **Medical Equipment, Devices and Supplies**
- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - Non-Medically Necessary enhancements to standard equipment and devices.
 - Supplies, equipment and appliances, including hearing aids and wigs, that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense, including items you purchase with features that exceed what is Medically Necessary, will be limited to the Maximum Allowed Amount for the standard item, and the additional costs will be your responsibility.
 - Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What’s Covered” section.
 - Continuous glucose monitoring systems. These are covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.
- 49) **Medicare** For which benefits are payable under Medicare Parts A, and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in “General Provisions.” If you do not enroll in Medicare Part B when you are eligible, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- 50) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.
- 51) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 52) **Non-Approved Drugs** Drugs not approved by the FDA.
- 53) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.
- 54) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- 55) **Off Label use** Off label use, unless we must cover it by law or if we, or the PBM, approve it. Prescription drugs approved by the Federal Drug Administration (FDB) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.
- 56) **Oral Surgery** Extraction of teeth, and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

57) **Ovulation** kits and sperm testing kits and supplies.

58) **Personal Care, Convenience and Mobile/Wearable Devices**

- Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
- First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
- Home workout or therapy equipment, including treadmills and home gyms,
- Pools, whirlpools, spas, or hydrotherapy equipment.
- Hypo-allergenic pillows, mattresses, or waterbeds,
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

59) **Private Duty Nursing** Private Duty Nursing Services unless listed as covered in this Booklet. Your coverage does not include benefits for private duty nursing in the inpatient setting.

60) **Prosthetics** Prosthetics are not covered for the following:

- Cosmetic purposes (including wigs and scalp hair prosthetics);
- Sports prosthesis for members 18 years of age or older.

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

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
- Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or Mental Health or Substance Use Disorder diagnosis or condition in an outdoor environment including wilderness, adventure, outdoor programs or camps.

62) **Routine Physicals and Immunizations** Physical exams and Immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

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

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

- 65) **Sexual Dysfunction** Services or supplies for male or female sexual problems.
- 66) **Sport, Contest, or Competition** For expenses incurred for the treatment of accidents or injuries resulting from the participation in interscholastic, intercollegiate, or professional sport, contest or competition; traveling to or from such sport, club, contest or competition as a participant; or while participating in any practice or conditioning program for such sport, contest, or competition to the extent such accidents or injuries are covered by an NCAA, NAIA, or student athletic department accident or injury policy. In combination with insurance/benefits provided by these sources, students will not incur any more out-of-pocket costs than they, or any other student, would if covered solely by this Plan. Intramural sports are covered.
- 67) **Sport, Contest, or Competition** Injury sustained while:
- Participating in any intercollegiate or professional sport, contest or competition.
 - Traveling to or from such sport, contest or competition as a participant.
 - Participating in any practice or conditioning program for such sport, contest or competition.
- 68) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
- 69) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- 70) **Temporomandibular Joint Treatment** Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 71) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs.
- 72) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 73) **Vision Services** Coverage is not provided for services incurred for or in connection with any of the items below:
- Eyeglasses lenses, frames or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.
 - For safety glasses and accompanying frames.
 - For two pairs of glasses in lieu of bifocals.
 - For plano lenses (lenses that have no refractive power).
 - Lost or broken lenses or frames, unless the member has reached their normal interval for service when seeking replacements.
 - For services or supplies not specifically listed as covered in this Booklet.
 - Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
 - For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
 - Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
 - Blended lenses.
 - Oversize lenses.
 - For sunglasses.
- 74) **Waived Cost-Shares Out-of-network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- 75) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

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

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

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

What's Not Covered Under Your Prescription Drug Retail Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail Pharmacy benefit:

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial Non-Covered Services** Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
4. **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

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

5. **Compound Ingredients** Compound ingredients that are not FDA-approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
6. **Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
7. **Delivery Charges** Charges for delivery of Prescription Drugs.
8. **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy

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

9. **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to the “Prescription Drug List” in the section “Prescription Drug Benefits at a Retail Pharmacy” for details on requesting an exception.
10. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity limits set by the Plan or which are over any age limits based on FDA labeling.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Anthem.
13. **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the “What’s Covered” section..
14. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
15. **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
16. **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit, benefits may be available under the “Cellular and Gene Therapy Services” benefit. Please see that section for details.
17. **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
18. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
19. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the prescription drug benefit at a retail Pharmacy benefit may be covered under the Durable Medical Equipment (DME), Medical Devices, and Supplies benefit. Please see that section for details.
20. **Items Covered Under the “Allergy Services” Benefit** Allergy desensitization products or allergy serum. While not covered under the Prescription Drug Benefit at a Retail Pharmacy benefit, these items may be covered under the “Allergy Services” benefit. Please see that section for details.
21. **Lost or Stolen Drugs** Refills of lost or stolen Drugs.
22. **Mail Order Providers other than the PBM’s Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM’s Home Delivery Mail Order Provider, unless we must cover them by law.
23. **New Prescription Drugs, Indications, and/or Dosage Forms** New Prescription Drugs, new indications and/or new dosage forms will not be covered until the date they are reviewed and placed on a tier by our Pharmacy and Therapeutics (P&T) Process.
24. **Non-Approved Drugs** Drugs not approved by the FDA.

25. **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
26. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
27. **Off label use** Off label use, unless we must cover the use by law or if we, or the PBM, approve it.

Prescription drugs approved by the Federal Drug Administration (FDA) used for purposes not specified on their labels except for the diagnoses of cancer, HIV or AIDS, unless approved by us for medically accepted indications or as required by law.
28. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
29. **Over-the-Counter Items** Drugs, devices and products, or Prescription Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Drugs when any version or strength becomes available over the counter.

This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription. For additional information, please refer to the United States Preventive Services Task Force website: www.uspreventiveservicestaskforce.org
30. **Sanctioned or Excluded Providers** Any Drug, Drug regiment, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.
31. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
32. **Weight Loss Drugs** Any Drug mainly used for weight loss.

Additional Benefits

Additional Benefit for Accidental Death and Dismemberment Insurance

Student Only \$10,000 Maximum Benefit

Loss of Limb or Sight

If such covered Injury should independently of all other causes and within 90-365 days from the date of Injury solely result in any one of the following specific losses, we will pay a benefit to you according to the Schedule of Losses and Benefits, not to exceed the Maximum Benefit specified above. Payment will be made for each loss without regard to prior losses. But, the total benefit to be paid for two or more losses in any one accident will not exceed the Maximum Benefit of Accidental Death and Dismemberment insurance under the Policy on the date the accident occurred.

The benefit will be paid when we receive due written proof of loss as specified in this section. You must be insured by this coverage on the date the Injury occurred.

Accidental Death Benefit

If a covered Injury should independently of all other causes and within 90 – 365 days from the date of Injury solely result in your death, we will pay the benefit to your designated beneficiary(ies) up to the Maximum Benefit of Accidental Death and Dismemberment coverage under this Policy on the date the Injury occurred. This accidental death benefit will be paid when we receive due written proof that your death occurred. All benefits other than the accidental death benefit will be paid to you, the insured.

Definitions for Accelerated Death and Dismemberment Provision:

“Accident” or “Accidental” means accidental bodily Injury which is sustained independently of disease, illness, or bodily infirmity.

Illness” means:

1. a sickness that impairs a Student’s normal functioning of mind or body; and
2. the pregnancy, childbirth and related medical conditions of a Student

“Independent Medical Exam” means an examination by a Physician of the appropriate specialty for your condition at our expense. Such examination, scheduled by us, may be used for the purpose of determining eligibility for insurance or benefits under this provision.

“Injury” means bodily harm which is the direct result of an Accident and not related to any other cause.

Schedule of Losses and Benefits

Your Maximum Benefit is payable for the covered permanent loss of:

- Life
- Both hands, both feet, or sight of both eyes
- One hand and one foot
- Either one hand or one foot and sight of one eye

One-half of the Maximum Benefit, is payable for the covered permanent loss of:

- One hand
- One foot
- Sight of one eye

Covered dismemberment includes loss involving a hand, foot, or eye. Loss shall mean with regard to hands and feet, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. A surgically reattached hand or foot will be deemed a "permanent loss" if, 12 months after reattachment, the limb has regained less than 50% of its normal function.

No benefit will be paid by this coverage for a death or loss that results from, or that is caused directly, wholly or partly by:

- A bodily or mental infirmity or an illness or mental illness of any kind.
- Medical or surgical treatment of illness, or diagnostic or preventive care whether the loss results directly or indirectly from the treatment (unless the treatment or care is provided in connection with a loss).
- Any infection, unless it is pyogenic and occurs through and at the time of an accidental cut or wound.
- Poisoning in any form, including, but not limited to, ingestion or inhalation of gas, fumes, chemicals, drugs, alcohol or any combination thereof.
- Suicide or attempted suicide, while sane.
- Intentional self-injury while sane.
- Commission of, or attempt to commit, an assault or felony or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act.
- A war, or any act of war. "War" means declared or undeclared war and includes resistance to armed aggression.
- Participation in a riot or violent disorder. "Riot" means all forms of public violence, disorder, or disturbance of the public peace by three or more persons assembled together. It does not matter whether there was common intent or not and it does not matter whether or not damage to person or property or unlawful act was the intent or the consequence of such disorder.
- Being under the influence of any drug or substance. Conviction is not necessary for determination of being under the influence. This does not apply if the Student is using a drug or substance prescribed to the Student by a Physician. "Drug or substance" means any drug, narcotic, hallucinogen, barbiturate, amphetamine, gas or fumes, poison or any other controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as such act now exists, or is amended from time to time.
- Being intoxicated. Conviction is not necessary for determination of being intoxicated. "Intoxicated" means being legally intoxicated as determined by the laws of the jurisdiction where the accident occurred.
- Taking part in the sports of parachute jumping, sky diving or hang gliding.
- Professional riding, driving, or testing a motorized vehicle used in a race or speed contest.
- Any period while the Student is confined to a penal or correctional institution.
- Any loss or injury as a result of autoerotic asphyxiation, while sane.
- Any loss or injury which occurs while in the course of operating any Motorized Vehicle:
 - While the Student is under the influence of any intoxicant whether or not prescribed by a physician; or
 - If the Student's blood alcohol concentration is in excess of the legal limit in the state in which the accident or injury occurred.

"Motorized Vehicle" for the purpose of this provision means any self-propelled vehicle or conveyance, including but not limited to automobiles, trucks, motorcycles, ATV's, snow mobiles; tractors, golf carts, motorized scooters, lawn mowers, heavy equipment used for excavating, boats, and personal watercraft. "Motorized Vehicle" does not include a medically necessary motorized wheelchair.

Payment of Accidental Death Benefit

The interests of a designated beneficiary who dies before you will accrue to any surviving designated beneficiaries. However, if for all or part of your death benefit, no beneficiary has been properly designated in accordance with the Policy provisions and applicable law, the amount of your death benefit for which there is no beneficiary will be payable in equal shares to the first of the following categories of surviving beneficiaries:

1. Legal Spouse;
2. Natural and legally adopted children;
3. Mother and Father;
4. Brother and Sister;
5. Estate.

If you and the beneficiary die from the same accident, and the order of deaths cannot be determined, we will pay the benefit as though you survived the beneficiary.

BENEFICIARY DESIGNATION MAY NOT APPLY IN THE EVENT OF ANNULMENT OR DIVORCE:

Under Virginia law (Virginia Code 20-111.1), a revocable beneficiary designation in a policy owned by one spouse that names the other spouse as beneficiary becomes void upon the entry of a decree of annulment or divorce, and the death benefit prevented from passing to a former spouse will be paid as if the former spouse had predeceased the decedent. In the event of annulment or divorce proceedings, and if it is the intent of the parties that the beneficiary designation of the former spouse is to continue, you are advised to make certain that one of the following courses of action is taken prior to the entry of a decree of annulment or divorce: (i) change the beneficiary designation to make it irrevocable; (ii) change the ownership of the policy or contract; (iii) execute a separate agreement stating the intention of both parties that the beneficiary designation is to remain in effect beyond the date of entry of the decree of annulment or divorce; or (iv) make certain that the decree of annulment or divorce contains a provision stating that the beneficiary designation is not to be revoked pursuant to 20-111.

Physical Examinations

We shall have the right and opportunity to have any person whose Injury is the basis of a claim undergo an Independent Medical Exam. This may be done when and as often as we may reasonably require. If the person has died, we may require an autopsy, unless it is prohibited by law. Such examination or autopsy will be at our expense.

If Your Accidental Death and Dismemberment insurance ceases or is reduced, you cannot "convert" that insurance to an individual policy.

Additional Benefit for Emergency Medical Evacuation

Student Only

\$100,000 Maximum Benefit

We will pay benefits toward reimbursement of the expenses incurred transporting you back to your country of legal residence for medical care and treatment. The total amount of the benefit for medical evacuation will not be more than the Maximum Benefit Amount stated above.

While covered under this Policy, if You are in the United States and are on a School sponsored travel or assignment and suffer an accident, injury or sickness that results in a serious health condition which in the opinion of the attending Physician requires transportation to be treated adequately, we will arrange and pay for air and/or surface transportation, medical care during transportation, communication and all ancillary charges incurred in moving and transporting you to the nearest facility where appropriate medical care is available. This may be a location other than your home country.

After being treated at a medical facility, we will arrange and pay for transportation for you to your home country for further medical treatment or recovery.

No payment will be made for expenses resulting from:

- Expenses incurred before your effective date of coverage under this Policy.
- More than one emergency medical evacuation for any single medical condition during the Benefit Period.
- Any cost or expense not expressly covered in advance and in writing by us and/or not arranged by us. This exception shall not apply to emergency medical evacuation from remote or primitive areas when we cannot be contacted in advance and delay might reasonably be expected to result in loss of life or harm to you.
- Any expense incurred by you when travelling contrary to the advice of a medical practitioner, or for the purpose of obtaining medical treatment or for rest and recuperation following any prior accident or illness.
- Any expense incurred for emergency medical evacuation if you are not suffering from a serious medical condition, and/or you can be adequately treated locally, or treatment can be delayed until you return to your home country.
- Any expense incurred for emergency medical evacuation if you can travel as an ordinary passenger without a medical escort.
- Any expense related to you engaging in any form of aerial flight except as a passenger on a scheduled airline flight, as a passenger on a licensed charter fixed wing aircraft over an established route; or as a passenger travelling on a business related activity in a fixed wing aircraft owned or leased to you unless the form of aerial flight has been declared to and accepted by us in writing prior to travel.
- Any expense related to treatment performed or ordered by a non-registered practitioner not in accordance with the standard medical practice as defined in the country of treatment.
- Services furnished and billed by a Provider, unless such services or supplies are furnished in connection with an illness that commenced or injury that occurred, while you were in the United States.
- Any expense related to the cost of airfare for a family member or traveling companion accompanying you.

If your Medical Evacuation Benefit ceases, you cannot "convert" that insurance to an individual policy.

Additional Benefit for Repatriation of Remains

Student Only

\$ 60,000 Maximum Benefit Amount

If you die while covered under this Policy, this coverage pays benefits toward reimbursement of the expenses incurred for preparing and transporting your remains to your country of legal residence. The total amount of the benefit for repatriation will not be more than the Maximum Benefit Amount specified above.

1. Eligible expenses will include transportation of the body, and charges directly related to the preparation of the body for such transportation;
2. Transportation of the body will be to the first resting place (including, but not limited to, a funeral home or the place of interment) in proximity to the normal place of residence of the deceased; and
3. Satisfactory proof of the actual expenses will be required at the time of claim.

No payment will be made for expenses incurred for or in connection with:

- 1) Services before the effective date of the Plan.
- 2) Death outside the United States.

If your Repatriation of Remains Benefit ceases, you cannot "convert" that insurance to an individual policy.

Claims Payment

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

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

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

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

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

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

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. You may call the toll-free Member Services number on your ID card to determine the Maximum Allowed Amount for a particular Covered Service. Please see 'Inter-Plan Arrangements' later in this section for additional information.

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

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

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

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

When you receive Covered Services from a Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and

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

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

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

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

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

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

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

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

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

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

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

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

Member Cost Share

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

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

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

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. If we authorize a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You will not be liable for the difference between the Maximum Allowed Amount and the Out-of-Network

Provider's charge unless your claim involves a Surprise Billing Claim. Please contact Member Services for Authorized Services information or to request authorization.

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

Example:

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

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

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

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

Federal/State Taxes/Surcharges/Fees

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

Claims Review

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

Notice of Claim & Proof of Loss

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

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.
- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to us, or contact Member Services and ask for a claims form to be sent to you. We will send the form to you within 15 days. If you do not receive the claims form, within 15 days, you will have complied with the requirements of the Plan with respect to proof of loss, you can

still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

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

Out-of-Network claims must be submitted within 90 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 90-day period. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

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

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

Member's Cooperation

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

Payment of Benefits

You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. Where permitted by applicable law, we reserve the right to make payments directly to you as opposed to any Provider for Covered Service, at our discretion, except for claims for Emergency Care or Surprise Billing Claims for air ambulance services or non-Emergency services performed by Out-of-Network Providers at certain In-Network facilities, which will be paid directly to Providers and Facilities. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the College's Contract), or that person's custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or You) will discharge our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

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

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

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard[®] Program

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

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

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

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

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

B. Special Cases: Value-Based Programs

BlueCard[®] Program

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

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

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

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. Exceptions

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

E. Blue Cross Blue Shield Global Core[®] Program

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

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

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

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

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

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

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

- Doctors services;

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

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

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

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

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

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

Coordination of Benefits

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

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

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

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

Coordination of Benefits does not apply to Student Accidental Death and Dismemberment insurance, or Repatriation of Remains Expense insurance, or Emergency Medical Evacuation Expense insurance if included in this Plan.

The following are non-Allowable expenses:

- The amount that is subject to the Primary high-deductible health plan's deductible, if we have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue code of 1986.

When you have duplicate coverage:

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

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

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

We reserve the right to:

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

Credit toward deductible

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

Subrogation and Reimbursement

Subrogation: Payments Resulting from Claim or Legal Action

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

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

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

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

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

By accepting plan coverage you agree:

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

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

Complaints and Appeals and External Review Procedures

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

Complaints and Appeals

Complaints

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

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

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

Complaints Requiring Immediate Intervention

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

Concurrent review decisions.

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

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

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

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

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

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

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

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

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

Appeals

Level One Appeal Process

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

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

The decision will include:

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

When the finding is made, if the Member, or Member representative, does not agree with the finding, they may submit a voluntary second level Appeal to Anthem, request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem. The Superintendent of Insurance may be contacted toll-free at 1-800-300-5000.

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

Level Two Appeal Process

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

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

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

A Member has the right to:

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

If, after our denial, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

External Review Process

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

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

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

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

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

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

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

The Grievance should be sent to the following address:

For medical and Prescription Drug or Pharmacy Issues:

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

For Dental Issues

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

For Vision Issues

Blue View Vision
 Attn: Grievance Department
 PO Box 9304
 Minneapolis, MN 55440-9304

Limitation of Actions

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

Prescription Drug List Exceptions

Please refer to the "Prescription Drug List" section in the "Prescription Drug Benefit at a Retail Pharmacy" for the process to submit an exception request for Drugs not on the Prescription Drug list.

Eligibility and Enrollment – Adding Members

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

Who is Eligible for Coverage

The Student

All full-time registered graduate/undergraduate fee-paying dormitory International Students participants and athletes PEL (Program for Experienced Learners) students who are registered for on-site courses or courses taken in-residence, non-immigrant International, post doctorate, post baccalaureate, degree seeking graduate, students registered at an accredited institution of higher learning, students enrolled in Intensive English Language courses, visiting scholars under age 35 taking 6-12 or more credit hours per term in the Fall, Spring/Summer or Summer semester who have paid the student health fee are eligible to enroll in the Plan are automatically enrolled in the Plan at registration and the premium for coverage is added to their tuition billing are required to purchase the Plan, unless proof of comparable coverage is furnished. See Waiver of Coverage below for more information.

Dormitory students are automatically enrolled at the time of registration. The insurance coverage described in this Booklet is available to commuting Domestic students on an optional basis. Any family member who is a full time student may be insured as a Student or as a family member, but not as both.

All insured Students may purchase Accidental Death and Dismemberment Repatriation /Medical Evacuation Plan coverage on an optional basis.

Students must actively attend classes for at least the first [31][1-45] days after the date for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the Eligibility requirements that the Student actively attend classes. Anthem maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If Anthem discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Types of Coverage

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

- Student only (also referred to as single coverage)

When You Can Enroll

Enrollment

Students are automatically enrolled if they are eligible. Coverage for you and any enrolled Member becomes effective on the first day of the period for which Premium is paid or the date the enrollment form and full Premium are received by Anthem whichever is later.

Special Enrollment Periods

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

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving College contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Effective Date of Coverage and Special Enrollment Periods

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

Effective Dates for Special Enrollment periods

1. In the case of birth, adoption or placement for adoption or foster care, coverage is effective on the date of birth, adoption, or placement for adoption unless the Subscriber timely requests a different Effective Date;
2. In the case of marriage, coverage is effective on the first day of the month after We receive a complete application, as long as the application is received within 60 days of the event; and
3. In the case where an individual loses Minimum Essential Coverage, coverage is effective based on when we receive a complete application, which must be submitted within 60 days of the qualifying event.

Effective Dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing:
 - Individual who no longer resides, lives or works in the Plan's Service Area,
 - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
 - Termination of employer contributions, and
 - Exhaustion of COBRA benefits.

Effective Dates for Special Enrollment due to loss of Minimum Essential Coverage do not include termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Updating Coverage

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

- Changes in address;
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare due to age;

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

If you withdraw from school or request cancellation of coverage within the first 31 days of the coverage effective date, you will not be covered under the Policy and the full premium will be refunded. After 31 days from the effective date of coverage, you will be covered for the full period for which you have enrolled and no refund of premium will be allowed.

Nondiscrimination

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

Statements and Forms

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

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

Medical Leave of Absence

Students on an approved or required leave or suspension who were enrolled at the college or university and in the Student Health Insurance Plan during the 2025 academic year are eligible to enroll in this plan for up to two semesters.

Eligibility requirements:

- Student must have been enrolled at the college or university during the 2025-2026 academic year;
- Student must have been enrolled in the Student Health Insurance Plan for the 2025 policy year;
- Student intends to return to the college or university and remain a degree-seeking candidate.

Termination and Continuation of Coverage

Termination

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

- When the Contract between the College and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your College leaves the association. It will be the College's responsibility to notify you of the termination of coverage.
- If you cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the College and/or you must notify us immediately. The College and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 calendar day written advance notice before your coverage is retroactively terminated or rescinded. Such notice will contain clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact; an explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact; notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission; a description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and the date when the advance notice ends and the date back to which the coverage will be rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or Premium paid for such services. If your coverage is rescinded we will make an equitable adjustment of Premium to your University, taking into account benefits that may have been paid. Please see your University concerning any refund to which you may be entitled.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.

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

Removal of Members

Upon written request through the University, you may cancel your coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date.

Benefits After Termination Of Coverage

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

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

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

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

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

General Provisions

Assignment of Benefits

The benefits and rights you have under your contract with Anthem cannot be assigned by you by signing a form, by operation of law or by any other manner unless you get prior permission from Anthem in writing. The insured may assign benefits for care to the Provider of the care. An assignment of benefits does not affect or limit the payment of benefits otherwise payable under the Plan.

Care Coordination

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

Circumstances Beyond the Control of the Plan

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

Clerical Error

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

Confidentiality and Release of Information

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

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

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

Conformity with Law

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

Contract with Anthem

The College, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the College and us, Anthem Health Plans of Maine, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Maine. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries.

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

Entire Contract

Note: The laws of the state in which the College Contract is issued will apply unless otherwise stated herein.

This Booklet, the College Contract, the College application, any riders, endorsements or attachments, and the individual applications of the Student and Dependents constitute the entire Contract between the College and us and as of the Effective Date, supersede all other agreements. Any and all statements made to us by the College and any and all statements made to the College by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet. The statements you make on your application for coverage with us are representations and not warranties.

Examination of Insured

To ensure that all claims are valid, we may require the Member, as is reasonably required, to have a physical or mental examination at our expense. We reserve the right to request an autopsy at our expense, where it is not prohibited by law.

Form or Content of Booklet

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

Government Programs

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

Medical Policy and Technology Assessment

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

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Medicare

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

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

Member Rights and Responsibilities

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

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

Modifications

This Booklet allows the College to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the College and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the College about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

Not Liable for Provider Acts or Omissions

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

Payment Innovation Programs

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

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

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

Policies, Procedures, and Pilot Programs

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Group Contract, we have the authority, at our option, to introduce or terminate from time to time, pilot or test programs for disease management, care management, case management, clinical quality or wellness initiatives that may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. We may also offer, at our discretion, the ability for you to participate in certain voluntary health or condition-focused digital applications or use other technology based interactive tool, or receive educational information in order to help you stay engaged and motivated, manage your health, and assist in your overall health and well-being. The purpose of these programs and incentives includes, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue a program or incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (College-Member-Anthem)

The College is responsible for passing information to you. For example, if we give notice to the College, it is the College's responsibility to pass that information to you. The College is also responsible for passing eligibility data to us in a timely manner. If the College does not give us timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

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

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

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

Right of Recovery and Adjustment

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

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

Unauthorized Use of Identification Card

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

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to

Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

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

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to test for immediate results or collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs

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

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind

us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

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

Definitions

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

Accidental Injury

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

Ambulatory Surgery Center

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

Applied Behavior Analysis

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

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your claim is a Surprise Billing Claim. Please see "Claims Payment" section as well as the "Consolidated Appropriations Act of 2021 Notice" at the front of this Booklet for more details.

Autism Spectrum Disorder

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

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your College's effective or renewal date and lasts for 12 months. (See your College for details.) The Schedule of Benefits shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Biosimilar/Biosimilars

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

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is

part of the College Contract with your College, and is also subject to the terms of the Group Contract.

Brand Name Drugs

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

Capitation

"Capitation" means a set dollar payment per patient per unit of time, usually per month, that a carrier pays a health care practitioner, institutional provider or downstream entity to cover a specified set of services and administrative costs without regard to the actual number or nature of services provided. The services covered may include the downstream entity's own services, referral services or all medical services.

Clinical Peer

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

Coinsurance

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

Consolidated Appropriations Act of 2021

Please refer to the "Surprise Billing Protection Notices" at the front of this Booklet for details.

Controlled Substances

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

Copayment

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

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility except as described in “Benefits After Termination Of Coverage.”

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

Covered Transplant Procedure

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

Cryopreservation

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

Custodial Care

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

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

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

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

Deductible

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

Dentally Necessary Orthodontic Care

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

Designated Pharmacy Provider

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

Disability

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

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

Doctor

See the definition of "Physician."

Domestic Partner

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

Early Intervention Services

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

Effective Date

The date your coverage begins under this Plan.

Emergency Medical Condition

Please see the "What's Covered" section.

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

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

(2) A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another hospital.

The term “**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.

Emergency Care

Please see the "What's Covered" section.

Emergency service

Emergency service means a health care item or service furnished or required to evaluate and treat an emergency medical condition that is provided in an emergency facility or setting.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental Fertility Procedure

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

Experimental or Investigational (Experimental / Investigational)

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

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

- (a) The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:
- (i) cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (“FDA”) or any other state or federal regulatory agency and such final approval has not been granted; or
 - (ii) has been determined by the FDA to be contraindicated for the specific use; or
 - (iii) is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply, unless otherwise required by law; or
 - (iv) is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function; or
 - (v) is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as experimental or investigational or otherwise indicate that the safety, toxicity, or efficacy of

the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

- (b) Any Service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by Anthem. In determining whether a Service is Experimental or Investigational, Anthem will consider the information described in subsection (c) and assess the following:
 - (i) whether the scientific evidence is conclusory concerning the effect of the Service on health outcomes;
 - (ii) whether the evidence demonstrates the Service improves the net health outcomes of the total population for whom the Service might be proposed by producing beneficial effects that outweigh any harmful effects;
 - (iii) whether the evidence demonstrates the Service has been shown to be as beneficial for the total population for whom the Service might be proposed as any established alternatives; and
 - (iv) whether the evidence demonstrates the Service has been shown to improve the net health outcomes of the total population for whom the Service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- (c) The information considered or evaluated by Anthem to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under subsections (a) and (b) may include one or more items from the following list which is not all inclusive:
 - (i) published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
 - (ii) evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
 - (iii) documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
 - (iv) documents of an IRB or other similar body performing substantially the same function; or
 - (v) consent document(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
 - (vi) the written protocol(s) used by the treating physicians, other medical professionals, or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
 - (vii) medical records; or
 - (viii) the opinions of consulting providers and other experts in the field.

(d) Anthem identifies and weighs all information and determines all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Residential Treatment Center, or Skilled Nursing Facility, as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Fertility Treatment

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

Generic Drugs

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

Group Contract (or Contract)

The Contract between us, Anthem BCBS and the College (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the College. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Habilitative Services

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

Home Health Care Agency

A Provider licensed when required by law and approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that must satisfy our accreditation requirements and be approved by us.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care

Identification Card (ID Card)

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

Inborn Error of Metabolism

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

In-Network Provider

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

Infertility

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

Inpatient

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

Intensive In-Home Behavioral Health Program

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

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health or Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Interchangeable Biologic Product

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

meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Maintenance Medications

Please see the “Prescription Drug Benefit at a Retail Pharmacy section for details.

Maintenance Pharmacy

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

Maximum Allowed Amount

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

Medically Necessary Health Care

- ♦ Health care services or products provided to a member for the purpose of preventing, diagnosing, or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:
- ♦ Consistent with generally accepted standards of medical practice;
- ♦ Clinically appropriate in terms of type, frequency, extent, site and duration;
- ♦ Demonstrated through scientific evidence to be effective in improving health outcomes;
- ♦ Representative of “best practices” in the medical profession; and
- ♦ Not primarily for the convenience of the member or physician or other health care practitioner.

When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a Specialty Drug provided in the Outpatient department of a Hospital if the drug could be provided in a physician’s office or the home setting.

Member

People, including the Student, who has met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called “you” and “your” in this Booklet.

Mental Health and Substance Use Disorder

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

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

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

Out-of-Pocket Limit

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

Partial Hospitalization Program

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

Pharmacy

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

Pharmacy and Therapeutics (P&T) Process

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

Pharmacy Benefits Manager (PBM)

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

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

Physician (Doctor)

Includes the following when licensed by law:

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

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

Plan and Plan Year

The benefit plan your College has purchased, which is described in this Booklet. The Plan Year means the period of time by which the College renews its Group Contract with us.

Precertification

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

Premium (also known as Subscription Charge)

The amount that you must pay to be covered by this Plan. This may be based on your age and will depend on the College's Contract with us.

Prescription Drug (Drug)

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

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

Prescription Order

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

Primary Care Physician ("PCP")

A Physician, in person or virtually, who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

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

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, must satisfy our accreditation requirements and be approved by us. Details on our accreditation requirements can be found at <https://www.anthem.com/provider/credentialing/>. This includes any Provider that state law says we must cover when they give you Covered Services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card. Examples of Providers include, but are not limited to: Clinical professional counselors, dentists, essential health care providers (rural health clinics) and essential community providers, registered nurse first assistants, social workers, certified nurse midwives, independent dental hygienists, dental therapists, naturopathic doctors, registered nurse anesthetists, and psychiatric nurses.

Qualifying Payment Amount

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

Recognized Amount

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

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

Recovery

Please see the "Subrogation and Reimbursement" section for details.

Referral

Please see the "How Your Plan Works" section for details.

Rehabilitative Services

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

Residential Treatment Center / Facility:

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

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Health Clinic

A free-standing center providing episodic health services without appointments for diagnosis; care; and treatment.

These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

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

Site of Service Provider

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

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

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

Skilled Nursing Facility

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

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

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the "Eligibility and Enrollment – Adding Members" section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Student

A student who is eligible for and has enrolled in the Plan according to the rules stated under the "Eligibility and Enrollment – Adding Members" section.

Surgical Assistant

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

Surprise Billing Claim

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

Telehealth

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

Treatment of Autism Spectrum Disorders

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

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

University or School

The educational institution which has a Group Contract with Anthem Blue Cross and Blue Shield, and which sponsors this Plan.

Urgent Care

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

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.



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