Certificate of Coverage

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

Anthem Student Advantage IN SHIP Blue Access Plan

Indiana University Student Academic Appointees (SAA), Appointed Pre and Postdoctoral Fellows and Fellowship Recipients

08-01-2026



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente al número 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.

Anthem Insurance Companies, Inc.
220 Virginia Avenue
Indianapolis, Indiana 46204

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

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

Surprise Billing Claims

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

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

Surprise Billing Claims also include Claims that are subject to the Indiana Surprise Billing law (described below).

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

Except as provided in the Indiana Surprise Billing law section below, 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 Service had been furnished by an In-Network Provider. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology 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 by obtaining your written consent not later than 5 business days prior to the delivery of services.

Out-of-Network Air Ambulance Services

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

How Cost-Shares Are Calculated

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

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility, or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprise 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 "Grievance and External Review Procedures" section of this Benefit Book.

Provider Directories

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

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.

Indiana Surprise Billing Law Notice

If you receive non-Emergency Care from an Out-of-Network professional Provider at an In-Network Facility, your cost shares will be calculated using the Plan's Maximum Allowed Amount. Out-of-Network professional Providers may bill you for any difference between the Maximum Allowed Amount and the Out-of-Network professional Providers' billed charges only if the Our-of-Network professional Provider gives you proper notice of its charges not later than 5 business days prior to the delivery of scheduled services, and obtains your signed written consent to the charges This section of the Indiana Surprise Billing Law Notice controls whenever there is a conflict with the Consolidated Appropriations Act of 2021 notice above. For purposes of the "Indiana Surprise Billing law" an "Out-of-Network professional provider" includes any individual licensed by a board in Indiana Code 25-0.5-11-1, except for a dentist, optometrist, or provider facility.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

Additional Federal Notices

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

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).

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 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 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 School 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 School 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 Students 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; or
- The Student or Dependent becomes eligible for a subsidy (state premium assistance program)

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 University.

Notices Required by State Law

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.
1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395
Complaints can be filed electronically at *www.in.gov/idoi*

Notice of Protection Provided by The Indiana Life and Health Insurance Guaranty Association Disclaimer

This Notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policyholders. This safety net was created under Indiana law, which determines who and what is covered and the amounts of coverage.

ILHIGA was established to provide protection to policyholders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after July 1, 2018. The benefits that ILHIGA is obligated to cover are not to exceed the lesser of (a) the contractual obligations for which the member insurer is liable or would have been liable if the member insurer were not an insolvent insurer, or (b) the limits indicated below:

Life Insurance

- $300,000 in death benefits
- $100,000 in net cash surrender or net cash withdrawal values

Health Insurance

- $500,000 for health plan benefits (see definition below)
- $300,000 in disability income and long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities

- $250,000 in present value of annuity benefits (including net cash surrender and net cash withdrawal values)

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans and covered unallocated annuities.

"Health benefit plan" is defined in IC 27-8-8-2(o), and generally includes hospital or medical expense policies, certificates, HMO subscriber contracts or certificates or other similar health contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as accident-only, credit, dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than the contractual obligations in the life, annuity or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this Notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or variable annuity contract.

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity to which it relates.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at *www.inlifega.org* or contact:

Indiana Life & Health Insurance Guaranty Association
3502 Woodview Trace, Suite 100
Indianapolis, IN 46268
(317) 636-8204

Indiana Department of Insurance
311 W. Washington Street, Suite 103
Indianapolis, IN 46204
(317) 232-2385

The policy or contract that this Notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Insurance Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance or HMO coverage. (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this Notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

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

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Blanket Master Contract issued to your University, and the Plan that your University chose for you. The Group Blanket Master 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., University, 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 Insurance Companies, Inc. dba 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 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!

Indiana University Health Centers

Your health care needs may best be satisfied in a convenient, cost-effective manner by the health care providers at one of the Indiana University Campus Health Centers, if there is one at your location. Plan Deductibles are waived for services rendered at the campus health centers on the Bloomington and IUPUI campuses. The health centers provide care for acute illnesses and certain ongoing conditions, such as asthma, as well as contraceptive counseling and immunizations. A referral is not required to be seen at the health centers. Please note that not all services provided at the campus health centers will be covered by the Student Health Insurance 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.



President

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Schedule of Benefits

Actuarial Value 91.10%

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

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

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

Deductible	In-Network	Out-of-Network
Per Member	$0	$700
Per Family	$0	$2,100

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

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

The Deductible does not include amounts you pay for following benefits:

- Services from Indiana University Student Health Centers.
- In-Network Pediatric Dental Services and In-Network and Out-of-Network Pediatric Vision Services.

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

Coinsurance	In-Network	Out-of-Network
Plan Pays	80%	50%
Member Pays	20%	50%

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

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

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	$2,500	$5,000
Per Family	$5,000	$10,000

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.

The out-of-pocket Limit does not include amounts you pay for following benefits:

- Out-of-Network Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services.
- Services from Indiana University Health Centers.

No one person covered under a family plan will pay more than their individual out-of-pocket Limit. Once the out-of-pocket Limit is satisfied, you will not have to pay any additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above. The In-Network and Out-of-Network out-of-pocket Limits are separate and do not apply toward each other.

Important Notice about Your Cost Shares

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

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

Benefits	In-Network	Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Ground, Air, and Water) Emergency Services For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment.	20% Coinsurance	
Ambulance Services (Ground, Air, and Water) Non-Emergency Services For ground or water ambulance services, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. This does not apply to air ambulance services. For air ambulance services, Out-of-Network Providers cannot bill you for more than your applicable In-Network Deductible, Coinsurance, and/or Copayment. **Important Note:** Non-Emergency ambulance services are subject to Medical Necessity reviews by us. Please see "Getting Approval for Benefits" and "What's Covered" for more details. Benefits for non-Emergency ground or water ambulance services will be limited to $50,000 per trip if an Out-of-Network Provider is used. This limit does not apply to air ambulance services	20% Coinsurance	
Autism Spectrum Disorders	Benefits are based on the setting in which Covered Services are received.	
Cardiac Rehabilitation	Please see "Therapy Services."	

Benefits	In-Network	Out-of-Network
Cellular and Gene Therapy Services Precertification required	See the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" section later in this Schedule.	
Chemotherapy	Please see "Therapy Services."	
Chronic Pain Management Services	Benefits are based on the setting in which Covered Services are received.	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Dental Services for Members Through the end of the month in which they turn 19 **Note:** To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your ID card.		
• **Diagnostic and Preventive Services**	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• **Basic Restorative Services**	20% Coinsurance	20% Coinsurance
• **Endodontic Services**	50% Coinsurance	50% 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) (Limited to services for accidental injury, or to prepare the mouth for certain medical treatments)	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care." Benefits for diabetic education are based on the setting in which Covered Services are received.	20% Coinsurance	50% Coinsurance after Deductible
Diagnostic Services		
• Reference Labs	20% Coinsurance	50% Coinsurance after Deductible
• All Other Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME), Medical Devices, and Supplies		
• Durable Medical Equipment	20% Coinsurance	50% Coinsurance after Deductible
• Orthotics	20% Coinsurance	50% Coinsurance after Deductible
• Prosthetics	20% Coinsurance	50% Coinsurance after Deductible
• Medical and Surgical Supplies	20% Coinsurance	50% Coinsurance after Deductible
The cost shares listed above apply when your Provider submits separate bills for the equipment or supplies. Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, and Copayment as any other service under this Plan.		
• Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period, In- and Out-of-Network combined	
The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices and supplies 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.		

Benefits	In-Network	Out-of-Network
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$150 Copayment per visit Copayment waived if admitted	
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon)	No Copayment, Deductible, or Coinsurance	
• Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	No Copayment, Deductible, or Coinsurance	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	
As described in the "Consolidated Appropriations Act of 2021 Notice" and the "Indiana Surprise Billing Law 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 more details.		
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Therapy Services" for details on Benefit Maximums.	
Home Health Care		
• Home Health Care Visits from a Home Health Care Agency Including intermittent skilled nursing services)	20% Coinsurance	50% Coinsurance after Deductible
• Home Dialysis	20% Coinsurance	50% Coinsurance after Deductible
• Home Infusion Therapy/ Chemotherapy	20% Coinsurance	50% Coinsurance after Deductible
• Specialty Prescription Drugs for Infusion / Injection – Other than Chemotherapy	20% Coinsurance	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Other Home Health Care Services / Supplies	20% Coinsurance	50% Coinsurance after Deductible
• Private Duty Nursing (Including continuous complex skilled nursing services)	20% Coinsurance	50% Coinsurance after Deductible
Home Health Care Benefit Maximum	100 visits per Benefit Period, The limit includes Private Duty Nursing and Therapy Services (e.g., physical, speech, occupational, cardiac and pulmonary rehabilitation) given as part of the Home Health Care benefit. The limit does not apply to Home Infusion Therapy or Home Dialysis. *If Therapy Services are provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits and the Home Health Care limit will not apply.	
Home Infusion Therapy	Please see “Home Health Care.”	
Hospice Care		
• Home Hospice Care	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Bereavement	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Inpatient Hospice	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Outpatient Hospice	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
• Respite Care	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	$200 Copayment per admission	50% Coinsurance after Deductible
• Skilled Nursing Facility	$200 Copayment per admission	50% Coinsurance after Deductible
• Rehabilitation	$200 Copayment per admission	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum	Unlimited days per Benefit Period, In- and Out-of-Network combined	
Skilled Nursing Facility Benefit Maximum	90 days per Benefit Period, In- and Out-of-Network combined	
• Mental Health / Substance Use Disorder Facility	$200 Copayment per admission	50% Coinsurance after Deductible
• Residential Treatment Center for Mental Health and Substance Use Disorders	$200 Copayment per admission	50% Coinsurance after Deductible
• Ancillary Services	$200 Copayment per admission	50% Coinsurance after Deductible
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	20% Coinsurance	50% Coinsurance after Deductible
• Surgery	20% Coinsurance	50% Coinsurance after Deductible
• Maternity	20% Coinsurance	50% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Services	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Maternity and Reproductive Health Services		
• Maternity Visits (Global fee for the ObGyn's prenatal, delivery, and postpartum services)	No Copayment, Deductible, or Coinsurance The Office Visit Copayment will also apply to the first prenatal visit.	50% Coinsurance after Deductible
• Inpatient Services (Delivery)	See "Inpatient Services"	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
Mental Health and Substance Use Disorder Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Occupational Therapy	Please see "Therapy Services."	

Benefits	In-Network	Out-of-Network
Office and Home* Visits		
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the “Outpatient Facility Services” section later in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
• Primary Care Physician / Provider (PCP) (Includes Ob/Gyn)	In-Person Visits: $25 Copayment per visit Virtual Visits: $25 Copayment per visit	50% Coinsurance after Deductible
• Additional Telehealth/Telemedicine Services from a Primary Care Provider (PCP) (as required by law)	$25 Copayment per visit	50% Coinsurance after Deductible
• Mental Health and Substance Use Disorder Provider (Including Psychotherapy and Habilitative / Rehabilitative Therapy Services)	In-Person Visits: $25 Copayment per visit Virtual Visits: $25 Copayment per visit	50% Coinsurance after Deductible
• Specialty Care Physician / Provider (SCP)	In-Person Visits: $35 Copayment per visit Virtual Visits: $35 Copayment per visit	50% Coinsurance after Deductible
• University Health Services (UHS)	$15 Copayment per visit No Deductible	
• Additional Telehealth/Telemedicine Services from a Specialty Care Provider (SCP) (as required by law)	$35 Copayment per visit	50% Coinsurance after Deductible
• Retail Health Clinic Visit	$25 Copayment per visit	50% Coinsurance after Deductible
• Family Planning, Diabetes Education and Nutritional Counseling	$25 Copayment per visit	50% Coinsurance after Deductible
• Nutritional Counseling (Mental Health and Substance Use Disorder)	$25 Copayment per visit	50% Coinsurance after Deductible
• Allergy Testing	20% Coinsurance	50% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance	50% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Diagnostic Lab (other than reference labs)	20% Coinsurance	50% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance	50% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	20% Coinsurance	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	50% Coinsurance after Deductible
• Office Surgery (including anesthesia)	20% Coinsurance	50% Coinsurance after Deductible
• Therapy Services:		
– Chiropractic / Osteopathic / Manipulative Therapy	$35 Copayment per visit	50% Coinsurance after Deductible
– Physical Therapy*	$35 Copayment per visit	50% Coinsurance after Deductible
– Speech Therapy*	$35 Copayment per visit	50% Coinsurance after Deductible
– Occupational Therapy*	$35 Copayment per visit	50% Coinsurance after Deductible
– Dialysis	$35 Copayment per visit	50% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	$35 Copayment per visit	50% Coinsurance after Deductible
– Cardiac Rehabilitation	$35 Copayment per visit	50% Coinsurance after Deductible
– Pulmonary Therapy	$35 Copayment per visit	50% Coinsurance after Deductible
– Cognitive Rehabilitation Therapy+	$35 Copayment per visit	50% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
+If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.		
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance	50% Coinsurance after Deductible
Orthotics	Please see “Durable Medical Equipment (DME) Medical Devices, and Supplies.”	

Benefits	In-Network	Out-of-Network
Outpatient Facility Services		
• Facility Surgery Charge	20% Coinsurance	50% Coinsurance after Deductible
• Facility Surgery Lab	20% Coinsurance	50% Coinsurance after Deductible
• Facility Surgery X-ray	20% Coinsurance	50% Coinsurance after Deductible
• Ancillary Services	20% Coinsurance	50% Coinsurance after Deductible
• Doctor Surgery Charges	20% Coinsurance	50% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant), Nutritional Counseling, and Diabetes Education	20% Coinsurance	50% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	20% Coinsurance	50% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Services		
Outpatient Facility Charges	20% Coinsurance	50% Coinsurance after Deductible
Professional Charges – Partial Hospitalization Program / Intensive Outpatient Program and Psychotherapy	20% Coinsurance 20% Coinsurance	50% Coinsurance after Deductible
Professional Charges – Nutritional Counseling and Habilitative / Rehabilitative Therapies		50% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance	50% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance	50% Coinsurance after Deductible
• Diagnostic Lab	20% Coinsurance	50% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance	50% Coinsurance after Deductible
• Other Diagnostic Tests (EKG, EEG, etc.)	20% Coinsurance	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Therapy:		
– Chiropractic / Osteopathic / Manipulative Therapy	20% Coinsurance	50% Coinsurance after Deductible
– Physical Therapy*	20% Coinsurance	50% Coinsurance after Deductible
– Speech Therapy*	20% Coinsurance	50% Coinsurance after Deductible
– Occupational Therapy*	20% Coinsurance	50% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance	50% Coinsurance after Deductible
– Dialysis	20% Coinsurance	50% Coinsurance after Deductible
– Cardiac Rehabilitation	20% Coinsurance	50% Coinsurance after Deductible
– Pulmonary Therapy	20% Coinsurance	50% Coinsurance after Deductible
– Cognitive Rehabilitation Therapy+	20% Coinsurance	50% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums. +If physical, occupational, speech, or cognitive rehabilitation therapy is provided for a Mental Health or Substance Use Disorder condition (based on the primary diagnosis on the claim form), benefits will be paid under the Mental Health and Substance Use Disorder benefits, as required by law.		
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	20% Coinsurance	50% Coinsurance after Deductible
Physical Therapy	Please see “Therapy Services.”	
Preventive Care	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Preventive Care for Chronic Conditions (per IRS guidelines)		
• Prescription Drugs	Please refer to the “Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits” section.	
• Medical items, equipment and screenings	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Please see the “What’s Covered” section for additional detail on IRS guidelines.		
Prosthetics	Please see “Durable Medical Equipment (DME) Medical Devices, and Supplies.”	
Pulmonary Therapy	Please see “Therapy Services.”	
Radiation Therapy	Please see “Therapy Services.”	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received. See “Inpatient Services” and “Therapy Services” for details on Benefit Maximums.	
Respiratory Therapy	Please see “Therapy Services.”	
Skilled Nursing Facility	Please see “Inpatient Services.”	
Speech Therapy	Please see “Therapy Services.”	
Surgery	Benefits are based on the setting in which Covered Services are received.	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
• Physical Therapy (Rehabilitative)	60 visits per Benefit Period	
• Physical Therapy (Habilitative)	60 visits per Benefit Period	
• Occupational Therapy (Rehabilitative)	60 visits per Benefit Period	
• Occupational Therapy (Habilitative)	60 visits per Benefit Period	

Benefits	In-Network	Out-of-Network
• Speech Therapy (Rehabilitative)	20 visits per Benefit Period	
• Speech Therapy (Habilitative)	20 visits per Benefit Period	
• Manipulation Therapy	12 visits per Benefit Period	
• Cardiac Rehabilitation	Unlimited	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Mental Health and Substance Use Disorder benefit (based on the primary diagnosis on the claim form).		
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: When you get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the Home Health Care Visit limit will apply instead of the Therapy Services limits listed above.		
Note: The visit limits for physical, occupational and speech therapy for habilitative services are separate from the visit limits for physical, occupational and speech therapy you get for any other rehabilitative therapy service.		
Transplant Services	Please see “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Service, Cellular and Gene Therapy Services.”	
Urgent Care Services (Office and Home* Visits)		
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.		
• Urgent Care Visit Charge	$50 Copayment per visit	50% Coinsurance after Deductible
• Allergy Testing	20% Coinsurance	50% Coinsurance after Deductible
• Shots/ Injections (other than allergy serum)	$25 Copayment per visit	50% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	$25 Copayment per visit	50% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	20% Coinsurance	50% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance	50% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	20% Coinsurance	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance	50% Coinsurance after Deductible
• Office Surgery (including anesthesia)	$50 Copayment per visit	50% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance	50% Coinsurance after Deductible
Note: If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		
Virtual Visits (from Virtual Care Only Providers)		
• Virtual Visits (including Primary Care) from Virtual Care-Only Providers (Medical Services)		$25 Copayment per visit
• Virtual Visits from Virtual Care-Only Providers (Mental Health and Substance Use Disorder Services)		$25 Copayment per visit
• Virtual Visits from Virtual Care-Only Providers (Specialty Care Services)		$35 Copayment per visit
If Preventive Care is provided during a Virtual Visit, it will be covered under the "Preventive Care" benefit, as required by law. Please refer to that section for details.		
Vision Services for Members Through the end of the month in which they turn 19 **Note:** To get the In-Network benefit, you must use an In-Network vision Provider. If you need help finding an In-Network vision Provider, please call us at the number on the back of your ID card.		
• Routine Eye Exam Limited to one exam per Benefit Period	$0 Copayment	$30 Copayment up to Maximum Allowed Amount
• Standard Plastic Lenses Limited to one set of lenses per Benefit Period. Available only if the contact lenses benefit is not used.		
Single Vision	$0 Copayment	$25 Copayment up to Maximum Allowed Amount
Bifocal	$0 Copayment	$40 Copayment up to Maximum Allowed Amount

Benefits	In-Network	Out-of-Network
Trifocal	$0 Copayment	$55 Copayment up to Maximum Allowed Amount
Standard Progressive	$0 Copayment	$40 Copayment up to Maximum Allowed Amount
Lenticular	$0 Copayment	$70 Copayment up to Maximum Allowed Amount
Note: Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received from In-Network providers.		
• Frames Limited to one set of frames from the Anthem Formulary per Benefit Period.	$0 Copayment	$45 Copayment up to Maximum Allowed Amount
• Contact Lenses Elective or non-elective contact lenses from the Anthem formulary are covered once per Benefit Period.		
Elective Contact Lenses (Conventional or Disposable)	$0 Copayment	$60 Copayment up to Maximum Allowed Amount
Non-Elective Contact Lenses	$0 Copayment	$210 Copayment up to Maximum Allowed Amount
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 eyeglass lenses until the next benefit period.		
Low Vision		
• Comprehensive low vision exam	$0 Copayment	Not covered
Limited to one per Benefit Period.		
• Optical/Non-optical aids/Supplemental Testing	$0 Copayment	Not covered
Limited to one occurrence of either optical/non-optical aids or supplemental testing per Benefit Period.		
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received.	

Benefits	In-Network	Out-of-Network
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services **Please call our Transplant Department as soon as you think you may need a Covered Procedure to talk about your benefit options. To get the In-Network Level of benefits under your Plan, you must get certain Covered Procedures from an Approved In-Network Provider.** Even if a Hospital is an In-Network Provider for other services, it may not be an Approved In-Network Provider for certain Covered Procedures. Please see the "What's Covered" section for further details. **The requirements described below do not apply to the following:** • Cornea transplants, which are covered as any other surgery; and • Any Covered Services related to a Covered Procedure that you get before or after the Benefit Period. Benefits for Covered Services that are not part of the Covered Procedure will be based on the setting in which Covered Services are received. Please see the "What's Covered" section for additional details.		

	Approved In-Network Provider	All Other Providers
Covered Procedure Benefit Period	The number of days or the applicable case rate / global time period will vary depending on the type of Covered Procedure and the Approved In-Network Provider agreement. Before and after the Covered Procedure Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending on where the service is performed.	Not applicable – There is no unique Benefit Period for services from All Other Providers
Inpatient Facility Services • **Precertification required**	20% Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your out-of-pocket Limit.

	Approved In-Network Provider	All Other Providers
Inpatient Professional and Ancillary (non-Hospital) Services	20% Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your out-of-pocket Limit.
Outpatient Facility Services • **Precertification required**	20% Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your out-of-pocket Limit.
Outpatient Facility Professional and Ancillary (non-Hospital) Services	20% Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your out-of-pocket Limit.
Travel Expenses		
• **Transportation and Lodging Limit**	Covered, as approved by us, up to $10,000 per Covered Procedure Benefit Period. In- and Out-of-Network combined.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Human Organ or Tissue Transplant Procedure	20% Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your out-of-pocket Limit.
• **Donor Search Limit**	Covered, as approved by us, up to $30,000 per transplant. In- and Out-of-Network combined.	
Live Donor Health Services		
• **Inpatient Facility Services**	20% Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your out-of-pocket Limit.

	Approved In-Network Provider	All Other Providers
• **Outpatient Facility Services**	20% Coinsurance	50% Coinsurance after Deductible. These charges will NOT apply to your out-of-pocket Limit.
Donor Health Service Limit	For Human Organ and Tissue Transplants, Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	**In-Network**	**Out-of-Network**
Each Prescription Drug will be subject to a cost share (e.g., Copayment / Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		
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.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days **Note:** A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply. When you get a 30-day supply, one Copayment per Prescription Order will apply.	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy (In-Network and Out-of-Network)	30 days* *See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
Note: Prescription Drugs that we are required to cover by federal law under the “Preventive Care” benefit will be covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.		
Retail Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$10 Copayment per Prescription Drug	50% Coinsurance
Tier 2 Prescription Drugs	$40 Copayment per Prescription Drug	50% Coinsurance

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Tier 3 Prescription Drugs	$75 Copayment per Prescription Drug	50% Coinsurance
Tier 4 Prescription Drugs	$150 Copayment per Prescription Drug	50% Coinsurance
Home Delivery Pharmacy Copayments / Coinsurance:		
Tier 1 Prescription Drugs	$20 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	$80 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	$150 Copayment per Prescription Drug	Not covered
Tier 4 Prescription Drugs	$150 Copayment per Prescription Drug	Not covered

Specialty Drug Copayments / Coinsurance:

Please note that certain Specialty Drugs are only available from a Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see **"**Specialty Pharmacy**"** in the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy for further details. When you get Specialty Drugs from a Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.

Also see the "Drug Cost Share Assistance Programs" section for information about applicable cost share amounts applicable to Specialty Drugs that are eligible for cost share assistance. Please note that Anthem may increase the cost shares listed above in order to take full advantage of cost share assistance that is available from drug manufacturers. This will lower plan costs but will not increase your cost because any additional cost share will be offset by the cost share assistance.

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

Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from an In-Network Pharmacy, Home Delivery Pharmacy, or Specialty Pharmacy Network. No Copayment /Coinsurance will apply to orally administered cancer chemotherapy you get from an Out-of-Network Pharmacy up to the Maximum Allowed Amount; you will be responsible for the amount that exceeds the Maximum Allowed Amount, up to billed charges. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.

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 have final authority to decide the Medical Necessity of the service.

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

To see a Doctor, 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 University's group or Member ID number.
- Tell them the reason for your visit.

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

In-Network Provider Services

For services from In-Network Providers:

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

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

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

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room. If you are experiencing a mental health crisis, you may also call 988 for assistance.

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

6. 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 "Consolidated Appropriations Act of 2021 Notice" and the "Indiana Surprise Billing Law Notice" 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.

Please note that not all In-Network Providers offer all services. For example, when you need Outpatient lab services, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Member Services before you get services for more information.

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:

1) An ongoing course of treatment for a life-threatening condition,
2) An ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy and post-operative visits), including chronic illness or condition that is degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time,
3) An ongoing course of treatment for pregnancy and through the postpartum period;
4) A scheduled non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such a surgery,
5) An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen your condition or interfere with anticipated outcomes, or
6) Continuing care benefits for Members undergoing a course of institutional or Inpatient care from the Provider or Facility and/or determined to be terminally ill and is receiving treatment for such illness from such Provider or Facility.

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

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

Your Cost- Shares

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

The BlueCard® Program

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

Identification Card

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.

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

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

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

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

Types of Reviews

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

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

    For admissions following Emergency Care, you, your authorized representative or Doctor must tell us of the admission as soon as possible. For childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same

time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

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

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

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

Who is Responsible for Precertification?

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

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	• The Provider must get Precertification when required
Out-of-Network/ Non-Participating	Member	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.
BlueCard Provider	Member (Except for Inpatient Admissions)	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary. • **BlueCard Providers must obtain Precertification for all Inpatient Admissions.**

Provider Network Status	Responsibility to Get Precertification	Comments
NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Doctor must tell us of the admission as soon as possible.		

How Decisions are Made

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

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

If you are not satisfied with our decision under this section of your benefits, please refer to the "Grievance and External Review Procedures" section to see what rights may be available to you.

Decision and Notice Requirements

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

We will accept a request for a Pre-service Reviews sent to us by your provider through secure electronic submission.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	48 hours from the receipt of all necessary information whichever is less.
Non-Urgent Pre-service Review	2 business days from the receipt of all necessary information.
Urgent Continued Stay/ Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of all necessary information
Urgent Continued Stay/ Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request or 2 business days from the receipt of all necessary information whichever is less

Type of Review	Timeframe Requirement for Decision and Notification
Non-urgent Continued Stay/ Concurrent Review for ongoing outpatient treatment	2 business days from the receipt of all necessary information
Peer-to-Peer Review	7 business days from the receipt of all necessary information
Post-Service Review	2 business days from the receipt of all necessary information

Necessary information includes the results of any face-to-face clinical evaluation, second opinion, or other clinical information that is directly applicable to the requested service that may be required. If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe, we will make a decision based upon the information we have.

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

Important Information

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

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

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

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

We also may identify certain Providers to review for potential fraud, waste, Use Disorder 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. 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 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.

What's Covered

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the "Schedule of Benefits" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How Your Plan Works" for more information on your Plan's rules. Read the "What's Not Covered" section for more 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 Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where and from whom you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the "Schedule of Benefits" for more details.

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. This also includes services rendered by an Emergency Medical Services Provider Organization within their scope of practice, performed or provided as basic and advanced life support services, performed or provided for specialty care transport, and performed or provided during a response initiated through the 911 system regardless of whether the patient is transported. If multiple Emergency Medical Services Provider Organizations qualify and submit a claim to Us, We:

  - May reimburse for one (1) claim per patient encounter; and
  - Reimburse the claim submitted by the Emergency Medical Services Provider Organization that performed or provided the majority of advanced life support services to you.

And one or more of the following are met:

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

- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;

- Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital;
- Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency ambulance services performed by an Out-of-Network Provider you do not need to pay any more than would have been paid for services from an In-Network Provider.

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

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

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

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

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Athletic Trainer Services

Your Plan covers services from an Athletic Trainer who is licensed under applicable Indiana state law and provides physical medicine and rehabilitative services within their scope of practice.

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under your Plan.

Behavioral Health Services

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

Biomarker Testing Services

This Plan provides coverage for Medically Necessary Biomarker Testing-when ordered by a qualified health care Provider operating within the Provider’s scope of practice for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member’s disease or condition when the test is sufficiently supported by medical and scientific evidence.

Biomarker Testing may require prior authorization depending on the type of test. Member may be financially responsible for charges/costs related to Biomarker Testing in whole or in part if the service and/or setting is not found to be Medically Necessary.

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 the section “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” for additional details.

Chemotherapy

Please see “Therapy Services” later in this section.

Chronic Pain Management Services

Evidence based health care products and services intended to relieve chronic pain that has lasted for at least three (3) months are covered under this Plan. This includes:

- Prescription drugs;

- Physical Therapy;
- Occupational Therapy;
- Chiropractic care;
- Osteopathic manipulative treatment; and
- Athletic Trainer Services.

See the sections “Athletic Trainer Services”, “Therapy Services” and “Prescription Drug Benefits at a Retail or Home Delivery (Mail Order) Pharmacy” for further details on the benefits for these services. As used in this section “Chronic pain" means pain that:

- persists beyond the usual course of an acute disease or healing of an injury; or
- may be associated with an acute or chronic pathologic process that causes continuous or intermittent pain for a period of months or years.

Clinical Trials

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

Benefits are limited to the following trials:

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

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

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

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

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

i. The Investigational item, device, or service;
ii. Items and services that 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.

Pediatric Dental Services for Members Through the end of the month in which they turn 19

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 Estimate

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 www.anthem.com 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

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. Please see the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic and Preventive Services

Oral Evaluations Covered 2 times per 12 months. The following oral evaluations are covered:

- Periodic
- Limited problem focused
- Comprehensive
- Comprehensive periodontal
- Oral Evaluation – under 3 years of age

Radiographs (X-rays)

- Bitewings – 2 series per 12 months. A series of bitewings can be two, three or four films. Vertical bitewings can include up to 7 or 8 films.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal(s).
- Cephalometric
- Oral facial images

Interpretation of diagnostic images by a practitioner not associated with capture of the image, including report.

Diagnostic Casts (also called Diagnostic Models)

Dental Cleaning (Prophylaxis) - Covered 2 times per 12 months. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (topical application of fluoride or fluoride varnish). Covered 2 times per 12-month period.

Sealants – per tooth. One sealant per tooth every 36 months.

Space Maintainers

Recement Space Maintainer

Basic Restorative Services

Emergency Treatment for the temporary relief of pain or infection.

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations

- Anterior teeth - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.
- Posterior teeth – Treatment to restore decayed or fractured permanent or primary posterior (back) teeth. Benefits shall be limited to the same surfaces and allowances for amalgam (silver filling). The Member must pay the difference in cost between the Plan's Maximum Allowed Amount for the Covered Service and the dentist's submitted fee for the optional treatment, plus any applicable Deductible or Coinsurance for the Covered Service.

Crown Pin Retention per tooth/restoration

Recement inlay, onlay or partial coverage restoration

Recement cast or prefabricated post and core

Recement crown

Pre-fabricated Stainless Steel Crown - Covered 1 time per 60-month period for eligible dependent children through the age of 14.

Pre-fabricated porcelain/ceramic crown – Covered for primary and permanent teeth once per 60-month period.

Placement of Interim Direct Restoration

Restorative Foundation for an Indirect Restoration

Full Mouth Debridement - Covered once per lifetime.

Periodontal Maintenance - Any combination of this procedure and dental cleanings (see the "Diagnostic and Preventive" section) is covered 4 times per 12-month period.

Periodontal scaling & root planing - Covered 1 time per quadrant per 24 months.

Partial pulpotomy for apexogenesis - Covered for permanent teeth only.

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

Treatment of Complications, post-surgical unusual complications

Therapeutic drug injection

Endodontic Services

Endodontic Therapy on Primary Teeth
- Pulpal therapy
- Therapeutic pulpotomy

Endodontic Therapy on Permanent Teeth
- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments

- Apexification - initial visit, interim medication replacement and final visit
- Apicoectomy - first root and each additional root
- Root amputation - per root
- Hemisection – includes any root removal only
- Surgical repair of root resorption
- Decoronation or submergence of an erupted tooth

Periodontal Services

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft; – 1st site and each additional site in quadrant;
- Soft tissue allograft;

Only one complex surgical periodontal service is covered per 36-month period per single permanent tooth or multiple teeth in the same quadrant.

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

- Pedicle soft tissue graft
- Autogenous and Non-Autogenous connective tissue graft (including donor site)
- Free soft tissue graft first tooth and additional teeth
- Subepithelial connective tissue graft

Crown Lengthening – Covered once per lifetime

Oral Surgery Services

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots
- Partial extraction for immediate implant placement – Once per tooth per lifetime.

Other Complex Surgical Procedures

- Removal of exostosis-per site
- Alveoloplasty – in conjunction with extractions
- Alveoloplasty – not in conjunction with extractions
- Bone replacement graft for ridge preservation-per site
- Incision and drainage of abscess (intraoral & extraoral soft tissue)
- Collect – apply autologous product- Covered once per 36 months.
- Excision of pericoronal gingiva
- Tooth reimplantation – accidently evulsed or displaced tooth
- Surgical exposure of impacted or unerupted tooth
- Corticotomy, per quadrant
- Suture of recent small wounds up to 5 cm and complicated sutures

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia – Covered when performed in connection with covered complex surgical services.

General anesthesia, intravenous conscious sedation and IV sedation will not be covered when performed with non-surgical dental care.

Major Restorative Services

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances. The patient must pay the difference in cost between the Plan's Maximum Allowed Amount for the Covered Service and the dentist's submitted fee for the optional treatment, plus any applicable Deductible and/or Coinsurance for the Covered Service

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once per 5 year period if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.

LIMITATION: If an onlay is performed to restore a posterior (back) tooth with porcelain or composite material, the patient must pay the difference in cost between the *maximum allowed amount* for the onlay with metallic material plus any deductible and/or coinsurance that applies.

Pre-fabricated stainless steel crown with resin – Receive the benefit equal to a prefabricated stainless steel crown. The patient must pay the difference in cost between the maximum allowed amount for the covered service and the dentist's submitted fee for the optional treatment, plus any deductible and/or coinsurance that applies.

Implant Crowns – Please see "Prosthodontic Services".

Crown/Inlay/Onlay/Veneer Repair

Core build-up, including any pins - Covered once per 60 months.

Prefabricated post and core in addition to crown - Covered once per tooth every 60 months.

Occlusal guards - soft and hard appliance, full arch. Covered once every 12 months for Members age 13 through 18.

Resin infiltration of smooth surface lesions – Covered once per 36 months.

Prosthodontic Services

Tissue Conditioning

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs for Complete Denture Base and Resin and Cast Partial Denture Base – upper and lower

Repairs, Replacement of Broken Clasp(s)

Replace Missing or Broken Artificial Teeth - complete and partial dentures, per tooth

Soft Liner for Complete or Removable Partial Denture - indirect

Complete Denture and Removable Partial Denture Adjustments

Removable Prosthetic Services

(**Dentures** and **Partial Dentures**) - Covered once per 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 60 months have elapsed since the last covered removable prosthetic appliance (denture or partial denture) and the existing appliance needs replacement because it cannot be repaired or adjusted. Immediate Partial Dentures are not covered.
- Types of dentures and partial dentures that are covered:
  Upper and Lower Complete Dentures
  Upper and Lower Immediate Partial Dentures
  Upper and Lower Partial Denture – resin base
  Upper and Lower Partial Denture - cast metal framework with resin base

Overdenture(s) (complete and partial denture upper and lower) - Benefit will equal the complete upper and lower denture or the upper and lower partial denture cast metal framework with resin denture bases. The patient must pay the difference between the maximum allowed amount for the benefited appliances and the overdenture(s), plus any deductible and/or coinsurance that applies.

Fixed Prosthodontic Services

Bridge - Covered once per 60 months

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all contract limitations on the *covered service*.

Recement Bridge (Fixed Partial Denture)

Bridge Repair, by report

Implant Services

Single Tooth Implant Body, Abutment and Crown - Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a *pretreatment estimate* be requested to estimate the amount of payment prior to beginning treatment.

Implant Supported Fixed and Removable Prosthetics (Crowns, Dentures, Partials and Bridges). Covered once per 60 months.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care. You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Dentally Necessary Orthodontic Care is 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. To be considered Dentally Necessary Orthodontic Care at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

Orthodontic treatment may include the following:

- **Limited Treatment** Treatments which are not full treatment cases and are usually done for minor tooth movement.

- **Comprehensive (complete) Treatment** Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.

- **Removable Appliance Therapy** An appliance that is removable and not cemented or bonded to the teeth.

- **Fixed Appliance Therapy** A component that is cemented or bonded to the teeth.

- **Pre-Orthodontic Treatment Visits**

- **Complex Surgical Procedures** Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Note: Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1. Monthly treatment visits that are inclusive of treatment cost;
2. Repair or replacement of lost/broken/stolen appliances;
3. Orthodontic retention/retainer as a separate service;
4. Retreatment and/or services for any treatment due to relapse;
5. Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6. Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments: Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six-month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

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.

Anesthesia and Hospital Charges for Dental Care

Your Plan covers anesthesia and Hospital charges for dental care, for a Member less than 20 years of age or a Member who is physically or mentally disabled, if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgery Center. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Diabetes Equipment, Education, and Supplies

Benefits include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Also covered is diabetes self-management training if you have insulin dependent diabetes, non-insulin dependent diabetes, or elevated glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician, a podiatrist; an advanced practice registered nurse or a physician assistant and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

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

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.
- The following Covered Services based on state law:

    - Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician.

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.

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.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

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. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;

3) Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act. This includes coverage for custom fabricated breast prostheses and one (1) additional breast prosthesis per breast affected by the mastectomy.
4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
5) Restoration prosthesis (composite facial prosthesis).
6) Wigs needed after cancer treatment limited to the maximum shown in the Schedule of Benefits.
7) Cochlear implants.

In addition, wearable cardioverter defibrillators and any necessary accessory and ongoing monitoring services are also Covered Services.

Prosthetic Limbs & Orthotic Custom Fabricated Brace or Support

Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

- Determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
- Not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment as other Covered Services under your Plan.

Medical and Surgical Supplies

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

Blood and Blood Products

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

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment. If you are experiencing a mental health crisis, you may also call 988 for assistance.

Emergency Services

Benefits are available in a Hospital Emergency Room or freestanding Emergency Facility for services and supplies to treat the onset of symptoms for an Emergency, which is defined below. **Services provided for conditions that do not meet the definition of Emergency will not be covered.**

Emergency (Emergency Condition)

"Emergency" or "Emergency Condition" means an accidental traumatic bodily injury or other medical or behavioral health condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to: (a) place an individual's health or the health of another person in serious jeopardy; (b) result in serious impairment to the individual's bodily functions; or (c)result in serious dysfunction of a bodily organ or part of the individual.

"Stabilize" means the provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Emergency Care

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

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. 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" and the "Indiana Surprise Billing Law 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. 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" and the "Indiana Surprise Billing Law Notice" at the front of this Booklet for more details on how this will impact your benefits.

Habilitative Services

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

Home Health Care Services

Benefits are available for 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. Your Doctor must also submit a plan of care to us, which must be approved in writing and will be reviewed at least every two (2) months. We may decide that a longer time between reviews is sufficient regularly.

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
- Private duty nursing services

Benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Mental Health and Substance Use Disorder Services" section below.

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

Home Infusion Therapy

Please see "Therapy Services" later in this section.

Hospice Care

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

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- 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, Cellular and Gene Therapy Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants as well as certain cellular and gene therapies. **To be eligible for coverage, we must approve the benefits in advance through Precertification and services must be performed by an approved In-Network Provider to be covered at the In-Network level.**

Certain transplants (e.g., cornea) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

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

Covered Procedure

As decided by us, a Covered Procedure includes:

- Any Medically Necessary human solid organ, tissue, and stem cell / bone marrow transplants and infusions, and

- Any Medically Necessary cellular or other gene therapies, and

- Any Medically Necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies,

Approved In-Network Provider

A Provider who has entered into an agreement with us to provide Covered Procedures to you. The agreement may only cover certain Covered Procedures or all Covered Procedures. 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 Procedures.

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

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 a Covered Procedure, as well Out-of-Network Providers.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department as soon as you think you may need a Covered Procedure to talk about your benefit options. You must do this before you receive services. We will help you maximize your benefits by giving you coverage information, including details on what is covered as well as information on any clinical coverage guidelines, medical policies, Approved In-Network Provider rules, or Exclusions that apply. Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator.

You or your Provider must call our Transplant Department for Precertification prior to the Covered Procedure whether this is performed in an Inpatient or Outpatient setting. Your Doctor must certify, and we must agree, that the Covered Procedure is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

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

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 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 or refer to IRS Publication 502.

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 city where the Covered Procedure is performed,
- 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 Covered Procedure,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation**,**
- Meals.

Infertility Services

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

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

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

- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

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

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.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

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

Maternity and Reproductive Health Services

Maternity Services

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

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed midwife;
- Routine nursery care for the newborn during the mother’s normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, and postpartum services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

Note: If a covered Member becomes pregnant as a surrogate, benefits are available to the Member and the fetus. Once the Member gives birth, no benefits are available to the newborn under this Plan.

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.

In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

- Phenylketonuria.
- Hypothyroidism.
- Hemoglobinopathies, including sickle cell anemia
- Galactosemia.
- Maple syrup urine disease.
- Homocystinuria.
- Inborn errors of metabolism that result in an intellectual disability and that are designated by State of Indiana
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry, if the State of Indiana determines that the technology is available for use by a designated laboratory under Indiana law.
- Spinal muscular atrophy
- Severe combined immunodeficiency
- Physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments
- Pulse oximetry screening examination at the earliest feasible time for the detection of low oxygen levels.
- Krabbe disease.
- Pompe disease.
- Hurler syndrome (MPS1).
- Adrenoleukodystrophy (ALD).

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Sterilization Services

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

Infertility Services

Important Note: Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).

Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

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, and Intensive Outpatient Programs and Intensive In-Home Behavioral Health Services.

- **Medication-Assisted Treatment** Drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for Substance Use Disorders, including opioid use disorder.

- **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 Mental Health Counselor (L.M.H.C.), or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office and Home Visits

Covered Services include:

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

Consultations between your Primary Care Physician and a Specialist, when approved by 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 on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

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

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

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

Prescription Drugs Administered in the Office

Orthotics

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

Outpatient Facility Services

Your Plan includes Covered Services in an:

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

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

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

Physical Therapy

Please see “Therapy Services” later in this section.

Pediatric Neuropsychiatric Disorders

This Plan provides coverage for treatment of Pediatric Neuropsychiatric Disorders for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS); and pediatric acute-onset neuropsychiatric syndrome (PANS) including treatment with intravenous immunoglobulin therapy. Coverage will not be subject to dollar limits, Deductibles, Copayment or Coinsurance that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to other coverage under your Plan.

Preventive Care

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

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

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
   a. Breast cancer,
   b. Cervical cancer,
   c. Colorectal cancer - This includes the preventive colonoscopy, anesthesia, polyp removal and pathology tests in connection with the preventive screening. It also includes a preventive screening following a positive non-invasive stool-based screening test or following a positive direct visualization test (i.e., flexible sigmoidoscopy, CT colonography),
   d. High blood pressure,
   e. Type 2 Diabetes Mellitus,
   f. Cholesterol,
   g. Child and adult obesity.

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

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

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

   a. Women’s contraceptives, sterilization treatments, and counseling. This includes Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives and patches and over-the-counter oral contraceptives (including emergency contraceptives) and male condoms. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. Some categories and classes of contraceptives do not have Generics available

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

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

c. Gestational diabetes screening.

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), related services and monitoring including follow-up HIV testing and additional testing to monitor the effects of the PrEP medications.

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

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

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests.
- Follow-up colonoscopy to a colorectal cancer screening test assigned either an "A" or "B" grade by the United States Preventive Services Task Force that was positive.

Preventive Care for Chronic Conditions (per IRS guidelines)

Members with certain chronic health conditions may be able to receive preventive care for those conditions prior to meeting their Deductible, when services are provided by an In-Network Provider]. These benefits are available if the care qualifies under guidelines provided by the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) (referred to as "the agencies").

This includes care for the following chronic conditions:

Preventive Care	For Members Diagnosed With
Blood pressure monitor	Hypertension
Retinopathy screening	Diabetes
Peak flow meters	Asthma
Glucometers	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Statins	Heart disease and/or diabetes

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

Prosthetics

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

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation Services

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

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

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 “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 (including services of a Certified Registered Nurse Anesthetist) and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

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 “Pediatric Dental Services for Members Through the end of the month in which they turn 19” for details.

Reconstructive Surgery

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

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

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;
- Chest wall reconstruction and aesthetic flat closure (as defined by the National Cancer Institute);
- 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.

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.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy –** Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis. We will not require you to receive dialysis treatment at an In-Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest In-Network Dialysis Facility is more than 30 miles from your home, we will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Infusion Therapy –** Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation –** Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive rehabilitation therapy –** Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy –** Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy –** Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

Please see "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services, Cellular and Gene Therapy Services" 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 Telemedicine / Telehealth visits that are appropriately provided as described below. This includes visits with Providers who also provide services in person, as well as online-only Providers.

- "Telemedicine / Telehealth" means the delivery of health care or other health services using electronic communications and information technology, in compliance with HIPAA including: live (synchronous) secure videoconferencing or secure instant messaging; store and forward (asynchronous) technology; or remote patient monitoring technology. Covered Services provided through Telemedicine/ Telehealth are provided to facilitate the medical exams, consultations, and behavioral health, including Substance Use Disorder evaluations and treatment. In-person contact between a Provider and the patient is not required for Telemedicine/ Telehealth 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 unless you have an already established relationship with the Provider. Benefits also do not include audio only telephone, reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside our network, benefit Precertification, or Provider to Provider discussions except as approved under "Office and Home Visits."

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

Vision Services for Members Through Age 19

These vision care services are covered for Members through the end of the month in which they turn 19. To receive the In-Network benefit, you must use a Blue View Vision provider. For help finding one, try Find a Doctor on our website or call 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

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55mm in:

- 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 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 – These are contacts you choose for comfort or appearance;
- Non-Elective Contact Lenses – These are contacts that are prescribed for certain eye conditions:
  - Keratoconus when your vision 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.
  - When your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

  Special Note: We will not pay for non-elective contact lenses for any Member that 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.

Vision Services (All Members / All Ages)

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

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

Prescription Drugs Administered by a Medical Provider

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

Important Details About Prescription Drug Coverage

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

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

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- 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. Please see the section "Step Therapy Protocol Exceptions" if you or your Doctor want to request an exception to a step therapy drug regimen,
- 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 a Grievance as outlined in the "Grievance and External Review Procedures" section of this Booklet.

Designated Pharmacy Provider

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

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

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

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

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

Therapeutic Equivalents

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

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

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

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

Prescription Drug Benefits

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

Prior Authorization

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

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

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- 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. Please see the section "Step Therapy Protocol Exceptions" if you or your Doctor want to request an exception to a step therapy drug regimen,
- Use of a Prescription Drug List (as described below).

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

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in our sole discretion, such change furthers the provision of cost effective, value based and/or quality services. If your prior authorization is for a Brand/Biologic agent, your authorization may be updated to a Generic/Biosimilar if one becomes available on the market before your authorization expires.

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 either a Retail Pharmacy or the PBM's Home Delivery Pharmacy.
- Specialty Drugs.
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit.
- Continuous glucose monitoring systems.*
  ***Note:** Each component of the monitoring system will be subject to a separate Copayment / Coinsurance.
- Self-injectable insulin and supplies and equipment used to administer insulin.
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Special food products or supplements when prescribed by a Doctor if we agree they are Medically Necessary. This includes medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.
- Flu Shots (including administration). These products will be covered under the "Preventive Care" benefit.
- Immunizations (including administration) required by the "Preventive Care" benefit.
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care" benefit.
- FDA approved smoking cessation products including over the counter nicotine replacement products when obtained with a Prescription for a Member age 18 or older. These products will be covered under the "Preventive Care" benefit.

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

Where You Can Get Prescription Drugs

In-Network Pharmacy

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

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

If we determine that a Pharmacy is dispensing Prescription Drug(s) in a way that is potentially wasteful or unsafe for you, we may require you to select a different Pharmacy to obtain your medication(s). If so, you will be notified, and benefits will continue to be paid when you use another In-Network Pharmacy.

Maintenance Pharmacy

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

Home Delivery Pharmacy

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

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. We will change the list from time to time. We may require you or your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy

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

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, compound Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products 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., oral, injection, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Prescription Drug List

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

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

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

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

Exception Request for a Drug not on the Prescription Drug List

If you or your Doctor believes you need a 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 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 within 72 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of your prescription, including refills.

You or your Doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the Plan. We will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If we deny coverage of the Drug, you have the right to request an external review by an IRO. The IRO will make a coverage decision 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.

Step Therapy Protocol Exceptions

If you or your Doctor want to request an exception for a Prescription Drug not recommended according to a step therapy protocol, you, your Doctor, or your pharmacist can get in touch with us by calling the Member Services number on your Identification Card or by visiting www.anthem.com. We will provide, in writing, a copy of the procedures for requesting a protocol exception.

Upon receipt of your protocol exception request or your appeal of a denial of a protocol exception request, We will review not more than:

- one (1) business day after receiving the request or appeal for urgent care situations; or
- three (3) business days after receiving the request or appeal for non-urgent care situations.

We will approve your protocol exception if any of the following apply:

- Your preceding Prescription Drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to you.
- Your preceding Prescription Drug is expected to be ineffective, based on both of the following:
  a. Your known clinical characteristic.
  b. Known characteristics of the previous prescription drug, as found in sound clinical evidence.
- You previously received: a preceding prescription drug; or another prescription drug that is in the same pharmacologic class or has the same mechanism of action as a preceding prescription drug; and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

- Based on clinical appropriateness, your preceding prescription drug is not in your best interest because your use of the preceding prescription drug is expected to:
  a. cause a significant barrier to your adherence to or compliance with your plan of care;
  b. worsen your comorbid condition; or
  c. decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

We may request a copy of relevant documentation from your medical records in support of the protocol exception.

We will notify both you and your Doctor if an exception is approved. 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. If we deny your exception request or appeal of a denied protocol exception request, We will provide you and your Doctor a notice of the denial, including a detailed, written explanation of the reason for the denial and the clinical rationale that supports the denial.

As used in this section:

"Protocol exception" means a determination by Us that, based on a review of a request for the determination and any supporting documentation: (1) a step therapy protocol is not medically appropriate for treatment of your particular condition; and (2) We will: (A) not require your use of a preceding prescription drug under the step therapy protocol; and (B) provide immediate coverage for another prescription drug that is prescribed for you.

"Step therapy protocol" means a protocol that specifies, as a condition of coverage under this Plan, the order in which certain prescription drugs must be used to treat your condition.
"Urgent care situation" means an injury or condition in which If medical care or treatment is not provided earlier than the time frame generally considered by the medical profession to be reasonable for a non-urgent situation, the injury or condition could seriously jeopardize your life.

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. We will work with the Pharmacy to decide when this should happen.

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

Therapeutic Equivalents

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

Split Fill Dispensing Program

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

Drug Cost Share Assistance Programs

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

Please note that Anthem may increase the cost share listed in the Schedule of Benefits in order to take full advantage of cost share assistance that is available from drug manufacturers. Any increase in the cost-share will not be more than 50% of the Maximum Allowed Amount. This will lower plan costs but will not increase your cost because any additional cost share will be offset by the cost share assistance.

In addition, because certain Specialty Drugs are not classified as “essential health benefits” under the Plan in accordance with the Affordable Care Act, any Member cost-share payments for these Specialty Drugs will not count towards the Plan’s Deductible or Out-of-Pocket Limit and will not be paid at 100% of the Maximum Allowed Amount after the Out-of-Pocket Limit is reached. A list of Specialty Drugs that are not considered to be “essential health benefits” is available. An exception process is available for determining whether a Specialty Drug that is not an essential health benefit is medically necessary for a particular individual.

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

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

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

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

Opting Out

If you do not wish to participate in this program, you can opt out, and you will be responsible for a portion of the cost of the Specialty Drug as noted in the Schedule of Benefits.

Special Programs

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

Rebate Impact on Prescriptions 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 final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1) **Abortion** Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions permitted under Indiana law.
2) **Administrative Charges**
    a) Charges to complete claim forms,
    b) Charges to get medical records or reports,
    c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
3) **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
    a) Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.
    b) Holistic medicine,
    c) Homeopathic medicine,
    d) Hypnosis,
    e) Aroma therapy,
    f) Massage and massage therapy, except for massage therapy services that are part of a physical therapy treatment plan and covered under the "Therapy Services" section of this Booklet,
    g) Reiki therapy,
    h) Herbal, vitamin or dietary products or therapies,
    i) Naturopathy,
    j) Thermography,
    k) Orthomolecular therapy,
    l) Contact reflex analysis,
    m) Bioenergetic synchronization technique (BEST),
    n) Iridology-study of the iris,
    o) Auditory integration therapy (AIT),
    p) Colonic irrigation,
    q) Magnetic innervation therapy,
    r) Electromagnetic therapy.
5) **Adaptive Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) for all indications except as described under Autism Services in the "What's Covered" section unless otherwise required by law.

6) **Autopsies** Autopsies and post-mortem testing.

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

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

9) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

10) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" and the "Indiana Surprise Billing Law Notice" in the front of this Booklet.

11) **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.

12) **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.

13) **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**.**

14) **Complications of/or Services Related to Non-Covered Services** Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

15) **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.

16) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

    This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.

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

18) **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.

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

20) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

21) **Delivery Charges** Charges for delivery of Prescription Drugs.

22) **Dental Services**

a) Dental care for Members age 19 or older.

b) Dental services or health care services not specifically covered under the Certificate (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code).

c) 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.

d) Enamel microabrasion and odontoplasty.

e) 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.

f) Placement or removal of sedative filling, base or liner used under a restoration.

g) Pulp vitality tests.

h) Secondary diagnostic tests in addition to the primary therapy.

i) Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

j) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.

k) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) nor the procedures used to prepare and place material(s) in the canals (tooth roots).

l) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.

m) Incomplete root canals.

n) Bacteriologic tests.

o) The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.

p) Provisional splinting, temporary procedures or interim stabilization.

q) Services of anesthesiologists, unless required by law.

r) Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.

s) Anesthesia Services, except by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.

t) Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.

u) 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.

v) Services for the replacement of an existing partial denture with a bridge

w) Interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).

x) Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.

y) Separate services billed when they are an inherent component of another covered service.

z) Cone beam images.

aa) Anatomical crown exposure.

bb) Temporary anchorage devices.

cc) Sinus augmentation.

dd) Repair or replacement of lost or broken appliances.

ee) Athletic mouth guards.

ff) Services to treat temporomandibular joint disorder (TMJ), unless covered by the medical benefits of this Certificate.

gg) Dental services for which you would have no legal obligation to pay in the absence of this or like coverage.

hh) For dental services received prior to the effective date of this Certificate or received after the coverage under this Certificate has ended.

23) **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

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

25) **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

26) **Drugs Prescribed by Providers Lacking Qualifications/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by us.

27) **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Preventive Care paragraph of the "What's Covered" section.

28) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

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

30) **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. Details on the criteria we use to determine if a Service is Experimental or Investigational is outlined below.

31) **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.

32) **Eye Exercises** Orthoptics and vision therapy. This Exclusion does not apply to Medically Necessary therapy to treat amblyopia.

33) **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.

34) **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.

35) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

    a) Cleaning and soaking the feet.

    b) Applying skin creams to care for skin tone.

    c) Other services that are given when there is not an illness, injury or symptom involving the foot.

36) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes, or as required by law.

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

38) **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

39) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers' Compensation, and services from free clinics.

    If your School or Dependent's employer is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

40) **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

41) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

42) **Hearing Aids** Hearing aids, including bone-anchored hearing aids, or exams to prescribe or fit hearing aids, including bone-anchored hearing aids and over-the-counter hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

43) **Home Care**

    a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.

    b) Food, housing, homemaker services and home delivered meals.

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

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

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

47) **Lost, Damaged, Destroyed or Stolen Drugs** Refills of lost, damaged, destroyed or stolen Drugs.

48) **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to “Habilitative Services” as described in the “What’s Covered” section.

49) **Medical Equipment, Devices and Supplies**

   a) Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

   b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

   c) Non-Medically Necessary enhancements to standard equipment and devices.

   d) Supplies, equipment and appliances, 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.

   e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “What's Covered” section.

50) **Medicare** For which benefits are payable under Medicare Parts A and/or B, except as required by law, as described in the section titled "Medicare-Eligible Members" in General Provisions.

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

52) **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 determined to be eligible for coverage by our Pharmacy and Therapeutics (P&T) Process.

53) **Non-approved Drugs** Drugs not approved by the FDA.

54) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.

55) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

56) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements not used to treat a specific medical condition or used primarily for the convenience of the Member or Provider. 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. except as described in this Booklet, or to supplements that we must cover by law.

57) **Off label use** Off label use, unless we approve it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.

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

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

   a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,

b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),

c) Home workout or therapy equipment, including treadmills and home gyms,

d) Pools, whirlpools, spas, or hydrotherapy equipment.

e) Hypoallergenic pillows, mattresses, or waterbeds,

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

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

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

61) **Prosthetics** Prosthetics for sports or cosmetic purposes. This exclusion does not apply to wigs needed after cancer treatment.

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

a. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included.

d) 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.

63) **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.

64) **School Health Services** Services and supplies normally provided by the University school health services, infirmary, Hospital, Pharmacy, or by health professionals who: are employed by; are affiliated with; have an agreement or arrangement with, or are otherwise designated by the University.

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

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

67) **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, 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.

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

69) **Sterilization** Services to reverse an elective sterilization.

70) **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).

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

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

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

74) **Vision Services**

   a) Eyeglass lenses, frames, or contact lenses for Members age 19 and older, unless listed as covered in this Booklet.

   b) Safety glasses and accompanying frames.

   c) For two pairs of glasses in lieu of bifocals.

   d) Plano lenses (lenses that have no refractive power).

   e) Lost or broken lenses or frames unless the member has reached their normal interval for service when seeking replacements.

   f) Vision services not listed as covered in this Booklet.

   g) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed as covered in this Booklet.

   h) Blended lenses.

   i) Oversize lenses.

   j) Sunglasses.

   k) 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.

   l) For Members through age 19, no benefits are available for frames or contact lenses not on the Anthem formulary.

   m) Visual therapy, such as orthoptics or vision training and any associated supplemental testing, unless covered by the medical benefits of this Booklet.

   n) For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, except as covered under the medical benefits of this plan.

   o) Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.

75) **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.

76) **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.

This Exclusion does not apply to weight management programs required under federal law as part of the “Preventive Care” benefit.

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

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

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

1. **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2. **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3. **Clinical Trial 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 Physician believes you require coverage for a certain Prescription Drug not on the list, please refer to “Prescription Drug List” in the section “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for details on requesting an exception.

10. **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
11. **Drugs Over the Quantity Prescribed or Refills After One Year** Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
12. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by us.
13. **Drugs Shared by Member** Any Drug prescribed to member that is subsequently shared with other individuals.
14. **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.
15. **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
16. **Fraud, Waste, Use Disorder, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, Use Disorder 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.
17. **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 "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" benefit in the "What's Covered" section. Please see that section for details.
18. **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.
19. **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).
20. **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT.)
21. **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment (DME), Medical Devices, and Supplies" benefit. Please see that section for details.
22. **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, these may be covered under the "Allergy Services" benefit. Please see that section for details.
23. **Lost, Damaged, Destroyed or Stolen Drugs** Refills of lost, damaged, destroyed or stolen Drugs.
24. **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.
25. **Non-approved Drugs** Drugs not approved by the FDA.
26. **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.

27. **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements not used to treat a specific medical condition or used primarily for the convenience of the Member or Provider. 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. This Exclusion does not apply to Medically Necessary total parenteral nutrition (TPN), enteral nutrition therapy, or special food products that we agree to cover, as described in this Booklet, or to supplements that we must cover by law.
28. **Off label use** Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
29. **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.
30. **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.
31. **Sanctioned or Excluded Providers** Any Drug, Drug regimen, 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.
32. **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.
33. **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
34. **Weight Loss Drugs** Prescription Drugs primarily indicated, used, or clinically effective for weight reduction or management, regardless of the FDA-approved indication. This Exclusion applies even when the Drug is prescribed for another condition if the Drug’s therapeutic benefits are mainly from weight loss. This Exclusion does not apply to Prescription Drugs prescribed for the treatment of diabetes.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES EXCLUSION

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 problem which we decide in our sole discretion to be Experimental or Investigational is not covered by your Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental or Investigational if we decide that one of more of the criteria listed below apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or

- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is given because of informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational, or otherwise show that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental or Investigational based on the criteria above may still be deemed Experimental or Investigational by us. In deciding whether a service is Experimental or Investigational, we will consider the information described below and assess whether:

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

The information considered or reviewed by us to decide whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational under the above criteria may include one or more items from the following list which is not all inclusive:

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

We have the sole authority and discretion to identify and weigh all information and decide all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational.

Claims Payment

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

Maximum Allowed Amount

General

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

The Maximum Allowed Amount for this 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; 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" and the "Indiana Surprise Billing Law Notice" at the front of this Booklet. Please refer to that section for further details.*

When you receive Covered Services from Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules, reimbursement policies, and/or reimbursement requirements. 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 Out-of-Network Provider fee schedule/rate, which we have established in our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

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

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

4. An amount negotiated by us or a third party vendor, which has been agreed to by the Provider. This may include rates for services coordinated through case management, or

5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

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 our 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 our Service Area, or a special negotiated price.

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

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

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

Member Cost Share

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

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

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.

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

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

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

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

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. If we authorize an In-Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless your 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 in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

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

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

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

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, Use Disorder 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 / Claims Forms / Proof of Loss

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

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we

will ask them for more details, and they will be required to supply those details within certain timeframes.

- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to us, or contact Member Services and ask for a claims form to be sent to you. We will send the form to you within 15 days. If you do not receive the claims form within 15 days, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:

  - Name of patient.
  - Patient's relationship with the Student.
  - 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. Failure to file a claim within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within such time, provided such proof is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time the claim is required to be filed. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

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

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper, except for claims for Emergency Care Services or Surprise Bills for Air Ambulance Services or non-Emergency Services performed by Out-of-Network Providers at certain In-Network Facilities, which will be paid within 30 calendar days of receipt of information necessary to determine claim payment. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

If we have not received the information we need to process a claim, we will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, we cannot complete the processing of the claim until the additional information requested has been received. We will make our request for additional information within 30 days of our initial receipt of the claim and will complete our processing of the claim within 15 days after our receipt of all requested information.

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. 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 Group's Plan), or that person's custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or You) will discharge our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to 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. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Programs

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 Programs." These Inter-Plan Programs 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 Programs. The Inter-Plan Programs 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 Programs Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Programs, 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. However, the Host Blue is responsible for

handling all interactions with its providers, including contracting with participating 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 consideration 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 consideration 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. Payments for Out-of-Network Emergency services, certain services provided by Out-of-Network Providers at In-Network Facilities, and Out-of-Network air ambulance services will be governed by applicable federal and state law.

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 Precertification. 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 Precertification 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 BlueCard Worldwide; 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

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

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

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

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

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. An Out-of-Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than Our Maximum Allowed Amount.

COB DEFINITIONS

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

1. Plan includes: Group and non-group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non-group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

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

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

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

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

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

The following are non-Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.

6. The amount that is subject to the Primary high-deductible health plan’s Deductible, if 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.

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

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

temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

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

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

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

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

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

Rule 1 - 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 Determination rules below apply.

Rule 2 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an Student, member, policyholder, or subscriber is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent, then the order of benefits between the two Plans is reversed so that the Plan covering you as an Student, member, policyholder, or subscriber is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 3 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

    - If a court decree states that one of the parents is responsible for the Dependent child's health

care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

- If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;

- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or

- If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

    - The Plan covering the Custodial parent;

    - The Plan covering the spouse of the Custodial parent;

    - The Plan covering the non-custodial parent; and then

    - The Plan covering the spouse of the non-custodial parent.

3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 4 - Active Student. The Plan that covers you as an active Student is the Primary Plan. The Plan also covering you as a Dependent of an active Student is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits.

Rule 5 - State Continuation Coverage. If you are covered under a right of continuation provided by state or other federal law and are covered under another Plan, the Plan covering you as a Student, member, subscriber or covering you as a Dependent of a Student, member, or subscriber is the Primary Plan and the state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits.

Rule 6 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 7. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans’ allowable

amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

1. We have paid or for whom we have paid; or
2. Any other person or organization that may be responsible for the benefits or services provided for the Member.

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

Subrogation and Reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

“Recovery” means is money you receive from another, their insurer or from any "Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Subrogation

We have the right to recover payments we make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits we have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable us to exercise our rights and do nothing to prejudice them.
- We have the right to take whatever legal action we see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full our subrogation claim and any claim still held by you, our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by us.

Reimbursement

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

- You must promptly reimburse us to the extent of benefits we paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, we shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to us immediately upon your receipt of the Recovery. You must reimburse us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by us.
- Any Recovery you obtain must not be dissipated or disbursed until such time as we have been repaid in accordance with these provisions.
- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

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

- In the event that you fail to disclose to us the amount of your settlement, we shall be entitled to deduct the amount of our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount we have paid or the amount of your settlement, whichever is less, directly from the Providers to whom we have made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and we would not have any obligation to pay the Provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved and any other information requested by us.
- You must cooperate with us in the investigation, settlement and protection of our rights.
- You must not do anything to prejudice our rights.
- You must send us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify us if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify us if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

Grievance and External Review Procedures

Definitions

“Appeal” means a formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

“Expedited Review” means the expedited handling of a Grievance or Appeal concerning our denial of certification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-Expedited Review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

“External Grievance” means your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Booklet.

“Grievance” means any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or Medically Necessary;
- a determination that a proposed service is Experimental or Investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan or the University and the Plan;
- Our decision to rescind coverage under this Booklet.

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with us on your behalf and to represent you in a Grievance or Appeal. If a Provider files a Grievance with us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, we must obtain a signed Designation of Representation form from you before we can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If we do not obtain a signed Designation of Representation form we will not continue to

research your Grievance until a signed Designation of Representation form is received or you have initiated a Grievance on your own.

We will accept oral or written comments, documents or other information relating to the Grievance and Appeal from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal. If, after our determination that you are appealing, 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(s) decision(s) on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If 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.

To obtain information on our Grievance procedures or to file a Grievance orally with us, please call the toll free Member Services number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

We will also accept Grievances filed in writing, including by facsimile or electronic means of communication. If you wish to file your Grievance in writing, mail it to:

For medical and Prescription Drug or Pharmacy Issues:
Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 105568
Atlanta, GA 30349-5568
Our facsimile number is 1-800-368-3238 if you wish to file your Grievance by fax.

For "Dental Benefits for Members Through Age 19" Issues:
Anthem Blue Cross and Blue Shield
Attn: Grievance Department
P.O. Box 1122
Minneapolis, MN
55440-1122

For "Vision Benefits for Members Through Age 19" Issues:
Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance Department
P.O. Box 9304
Minneapolis, MN 55440-9304

Upon our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from us), an acknowledgment will be sent to you within five (5) business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances we receive orally. All Grievances will be resolved by us within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from us).

If your Grievance cannot be resolved within 20 business days due to our need for additional information and your Grievance does not relate to an adverse Precertification decision (i.e., Prospective, Concurrent

or Retrospective review decision) or the denial of any other prior authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Non-Network Provider, or from you, and such information has not been received within 15 business days from our original request. In the event of the notice extension, we will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, we will make a determination based on the information in our possession.

For Grievances concerning adverse Precertification decisions or the denial of any other prior authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, we will send a letter to you notifying you of the decision reached.

Appeals

If our decision under the Grievance process is satisfactory to you, the matter is concluded. If our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. An acknowledgment will be sent to you within 5 business days upon our receipt of your Appeal request. We will set a date and time during normal business hours for our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting, unless your Appeal qualifies for Expedited Review. Appeals concerning adverse Precertification decisions or the denial of any other prior authorization required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by us. All other Appeals will be resolved by the panel no later than 30 business days from the date your Appeal request was received by us. After the Appeal panel makes a decision you will be notified within 5 business days in writing by us of our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- A Physician with knowledge of your medical condition believes that the standard appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of our receipt of sufficient information and will communicate our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of our determination to you, your attending Physician or ordering Provider, and the facility rendering the service. We will complete Expedited Review of an Appeal within three calendar days of our receipt of your Appeal request. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of our determination to you, your attending Physician or ordering Provider, and to the facility rendering the service.

External Grievance

If our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by us or an agent of Ours regarding a service proposed by your treating Provider:
   - an adverse utilization review determination; or
   - an adverse determination of Medical Necessity; or
   - a determination that a proposed service is Experimental/Investigational; or
2. Your Appeal is regarding our decision to rescind coverage under this Booklet; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal.

If an External Grievance is requested, we will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse our Appeal determination within seventy-two (72) hours if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and us of its determination within 72 hours after the External Grievance is filed if an urgent condition exists which would qualify for Expedited Review; or, within 72 hours after making the determination if the condition is non-urgent. If the independent review organization's determination is to reverse our Appeals decision, we will notify you or your Provider in writing of the steps we will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, we will not review a Grievance if it is not received by us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of our Appeal decision.

Prescription Drug List Exceptions

Please refer to the "Prescription Drug List", "Extension Request for a Drug Removed from the Prescription Drug List", and "Step Therapy Protocol Exceptions" sections in "Prescription Drug Benefit at a Home Delivery (Mail Order) Pharmacy" for the process to submit an exception request for Drugs not on the Prescription Drug List, removed from the Prescription Drug List, or that require Step Therapy.

You can learn more about our Grievance and Appeal process at the Indiana Department of Insurance website: http://www.in.gov/idoi/3008.htm

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 Benefits Department.

Who is Eligible for Coverage

The Student

All Student Academic Appointees, Appointed Pre and Postdoctoral Fellows and Fellowship Recipients, who meet the minimum eligibility requirements, are automatically enrolled in this Student Health Insurance plan each semester.

The Student is required to participate in this plan unless an approved waiver is on file by the waiver deadline. The Student must actively attend classes for at least the first 31 days of the coverage period.

The university pays the full cost for the Student's premium.

Eligible Appointees include:

- Student Academic Appointees appointed at 37.5 FTE or greater and enrolled in at least six credit hours or the G901 thesis/dissertation equivalent each semester (summer excluded).
- Appointed Pre or Postdoctoral Fellows, e.g. T-32 grants.
- Fellowship Recipients with an award of $6,750 or more per semester (Fall and/or Spring) and enrolled in at least six credit hours or the G901 thesis/dissertation equivalent each semester (summer excluded.

Exception

Coverage ends immediately for any Covered Person entering the armed forces of any country. A pro-rata refund of premium will be issued for the student and any covered dependents upon written request received within 90 days of withdrawal from school.

Dependents

Dependent eligibility is effective and expires concurrently with that of the insured, meaning coverage is only available to dependents if and when the student or scholar is insured under the plan.

To be eligible to enroll as a Dependent, you must fill out the enrollment form, pay the required Premium, and be one of the following:

- The Student's spouse (same- or opposite-sex) if legally married in one of the 50 U.S. states, the District of Columbia, a U.S. territory, or a foreign country; or
- The Student's or the Student's spouse's children, including biologic children, stepchildren, newborns and legally adopted children and children who the University has determined are covered under a Qualified Medical Child Support Order as defined by any applicable state law; or
- Children for whom the Student or the Student's spouse is the legal guardian; or
- as otherwise required by law.

Children are eligible to be covered up to age 26 (eligibility ends on the last day of the month they turn age 26), or any age if the child is fully disabled.

Notice of disability eligibility, along with supporting documentation, must be provided for enrollment.

If something changes that affects your dependent's eligibility, such as marriage, divorce or your child aging out of coverage, you must inform the university within 30 days of the event by completing the online Qualifying Event form. However, their coverage will end as of the date of the event, regardless of when you report it.

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

Types of Coverage

Your University 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);
- Student and spouse;
- Student and child;
- Student and children;
- Student and spouse and child;
- Student and family.

When You Can Enroll

Enrollment

Students whose participation is mandatory in an IU student insurance plan will be automatically enrolled. All other eligible groups, including adding dependents, must complete an enrollment form by the stated deadlines.

Coverage for the student and any enrolled dependent become effective on the first day of the period for which the Premium is paid or the date the enrollment form and full Premium are received by Anthem / University Health Plans (UHP), whichever is later.

To enroll the dependent(s) of a covered Student, complete the enrollment form available online at **www.universityhealthplans.com/Indiana** and select the appropriate tile based on your eligibility from the menu. A specific time will be allowed at the beginning of the Fall and Spring semesters for enrolling in the Plan. The completed dependent enrollment form and Premiums should be submitted directly to Anthem / University Health Plans (UHP).

If the dependent enrollment form is submitted after **the semester deadline**, it will not be accepted in the absence of an IRS qualifying life event, and the student will have to wait until the next semester enrollment period to enroll the dependent.

Special Enrollment Periods

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

Special Enrollment is available for eligible individuals who:

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

Medicaid and Children's Health Insurance Program Special Enrollment

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

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

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth for a period of 31 days. To continue coverage beyond the 31-day period you should submit an application / change form to the University, within 31 days following the birth, to add the newborn to your Plan if additional premium is needed to cover your newborn child.

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

Newborn children coverage will be for injury or sickness, including:

- The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and
- Medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects for cleft lip and cleft palate.

Adopted Children

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

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event. To continue coverage beyond the 31-day period you should submit an application / change form to the University, within 31 days following the adoption or placement for adoption, if additional premium is needed to cover your adopted child.

Adding a Child due to Award of Legal Custody or Guardianship

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

Qualified Medical Child Support Order

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

Updating Dependent Coverage and/or Removing Dependents

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

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

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

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, sexual orientation or identity, gender, or age.

Statements and Forms

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

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by you may result in termination of coverage.

Waiver and Termination of Coverage

Waiving Coverage

Student Academic Appointees (SAA), Appointed Pre and Postdoctoral Fellows and Fellowship Recipients: To waive coverage under this Plan, you must:

1. Submit an online waiver request by the waiver deadline.
2. Provide documentation showing enrollment in a comparable health insurance plan that meets University requirements.
3. Receive approval from Indiana University Human Resources.

A new waiver must be submitted each academic year.

Termination Effective Dates

The Insured Person’s insurance will terminate on the earliest of:

1. The date this Certificate terminates; or
2. For SAA and Pre & Postdocs, the end of the term of coverage for which Premium has been paid; or
3. For Fellowship Recipients, the end of the semester; or
4. The date the Insured Student enters military service; or
5. On any Premium due date the Policyholder fails to pay the required Premium for the Insured Student except as the result of an inadvertent error and subject to any Grace Period provision.

Termination of Coverage

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

- When the Group Blanket Master Contract between the University 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 University leaves the association. It will be the University's responsibility to notify you of the termination of coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the University and/or you must notify us immediately. The University 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 and the coverage of your dependents can be retroactively terminated or rescinded if: 1) your coverage has been in force for less than two years, or 2) the fraud or intentional misrepresentation of material fact concerns eligibility. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a “30 calendar day" advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.

- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the University. 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.

When your position or appointment with the University ends, you will have the opportunity to continue your coverage for yourself and your Dependent(s) for up to 3 months. You must elect coverage within 30 days of your loss of coverage. You can only make one election for either 1, 2 or 3 months at the time of enrollment. If you choose one month of coverage, you cannot re-enroll for additional months at a later time. Payment can be made by credit card at the time the continuation enrollment form is submitted.

Refund of Premium

Premiums received by Us are fully earned upon receipt. Refund of Premium will be considered only:

1. For any student who withdraws from School during the first 31 days of the period for which he or she is enrolled for a reason other than withdrawal due to Sickness or Injury. Such a student will not be covered under this Certificate and a full refund of the Premium will be made (less any claims paid) when written request is made within 90 days of withdrawal from School.
2. For an Insured Student entering the Armed Forces of any country. Such a student will not be covered under this Certificate as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made upon written request received by Us within 90 days of withdrawal from School.

Removal of Members

After the first 31 days of coverage, students and enrolled Dependents remain covered for the semester or academic year unless terminated under the Termination of Coverage provisions.

Information on Policy and Rate Changes

Insurance Premiums

How Premiums are Established and Changed – Premiums are the charges you and/or the University must pay us to get coverage. We figure out and set the required Premiums.

The University is responsible for paying the Premium to us according to the terms of the Contract. The University may have you contribute to the Premium cost. The University may choose to have your Premium determined by the age of the Student, with Premium set by age brackets. We may change membership Premiums on the annual date on which the University renews its coverage, or as otherwise permitted by applicable law. If the age of the Student is misstated at enrollment, all amounts payable for the correct age will be adjusted and billed to the University.

Grace Period – If the University fails to submit Premium payments to us in a timely manner, the University is entitled to a grace period of 31 days for the payment of such Premium. During the grace period, our Contract with the University shall continue in force unless the University gives us written notice of termination of the contract. If the University has obtained replacement coverage during the grace period, the Group Blanket Master Contract with us will be terminated as of the last day for which we have received Premium, and any and **all claims paid during the grace period will be retroactively adjusted to deny**. These claims that we retroactively deny should be submitted to the replacement carrier. If the University has **not** obtained replacement coverage during the grace period, or fails to inform us that it has not obtained replacement coverage, we will process any and all claims with dates of service during the grace period in accordance with the terms of this Booklet.

General Provisions

Assignment

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

Care Coordination

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, the Plan 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 Certificate 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 University 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 Blanket Master 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 University, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the University and us, Anthem Insurance Companies, 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 Indiana. 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 University, 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 Insurance Companies, Inc. and that no person, entity, or organization other than Anthem Insurance Companies, Inc. shall be held accountable or liable to the University for any of Anthem Insurance Companies, Inc.'s obligations to the University created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

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

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

Form or Content of Booklet

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

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, 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.

Legal Action

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 earlier than 60 days after we receive the claim or unless it is commenced within three years of our final decision on the claim or other request for benefits. If we decide a Grievance or an Appeal is untimely, our decision on the claim or other request for benefits from which the Grievance or Appeal was taken shall be considered our final decision, and the three-year period in which a lawsuit or legal action must be brought shall run from the date of that final decision, not the date on which Anthem decided the Grievance or Appeal was untimely. You must exhaust the internal Grievance or Appeals procedure before filing a lawsuit or taking other legal action of any kind against 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-Eligible Members

The Student and Dependents who are non-Medicare eligible and who reside in Indiana are eligible to enroll for coverage. A Member who is under age 65 at the time of enrollment but who later becomes eligible for Medicare Part A, B, C and/or Part D, is eligible to continue coverage with this coverage as secondary to any Medicare benefits. Medicare will be the primary carrier for such Members.

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 University 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 Blanket Master Contract, or by mutual agreement between the University 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 University 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 pay In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

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

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

Policies, Procedures, and Pilot Programs

We 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 Blanket Master Contract, we have the authority, in our sole discretion, 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 include, but are not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue a program or an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (University-Member-Anthem)

The University is responsible for passing information to you. For example, if we give notice to the University, it is the University's responsibility to pass that information to you. The University is also responsible for passing eligibility data to us in a timely manner. If the University does not give us with 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. 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 University 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 University has selected one of these options to make available to all Students, 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 University 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.

Approved In-Network Provider

Please see the **"**Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" benefit in the "What's Covered" section.

Athletic Trainer

Please see the "Athletic Trainer Services" benefit in the "What's Covered" section for details.

Authorized Service(s)

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

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 university's effective or renewal date and lasts for 12 months. (See your University 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.

Biomarker

A characteristic that is measured and evaluated as an indicator of normal biologic processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including but not limited to:

- Known gene-drug interaction for medications being considered for use or already being administered; and
- Gene mutations and protein expression.

Biomarker Testing

The analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker, including not limited to single-analyte tests, multiplex panel tests and whole genome sequencing.

Biosimilar/Biosimilars

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

Booklet

This document (also called the Certificate of Coverage), which describes the terms of your benefits. It is part of the Group Blanket Master Contract with your University, and is also subject to the terms of the Group Blanket Master Contract.

Brand Name Drug

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

Centers of Medical Excellence (COE) Network

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

Coinsurance

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

Consolidated Appropriations Act of 2021

Please refer to the "Consolidated Appropriations Act of 2021 Notice" and the "Indiana Surprise Billing Law Notice" 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 and the Maximum Allowed Amount.

Covered Procedure

Please see the **“**Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” benefit in the “What’s Covered” section.

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 “Termination and Continuation of Coverage.”

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

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.

Dependent

A member of the Student's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section and who has enrolled in the Plan.

Designated Pharmacy Provider

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

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Emergency Medical Services Provider Organization

A provider of Emergency medical services that is certified by the Indiana emergency medical services commission as an advanced life support provider organization under Indiana law.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

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 We determine to be unproven. For how this is determined, see the "What's Not Covered" section.
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.

Generic Drugs

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

Group Blanket Master Contract (or Contract)

The Contract between us, Anthem Insurance Companies, Inc., and the University (also known as the Group Blanket 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 Contract is kept on file by the University. If a conflict occurs between the Contract and this Booklet, the Contract controls.

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, University numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network

for one plan may not be In-Network for another. Please see “How to Find a Provider in the Network” in the section “How Your Plan Works” for more information on how to find an In-Network Provider for this Plan.

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 Health or Substance Use Disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by 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. 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 or Home Delivery (Mail Order) Pharmacy” section for details.

Maintenance Pharmacy

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

Maximum Allowed Amount

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

Medical Necessity (Medically Necessary)

An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by us to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member’s condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the

case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician's office or the home setting;
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider;
- Not otherwise subject to an exclusion under this Certificate.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Member

People, including the Student and his or her Dependents, 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. 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

The P&T Process is a two-step process used to make determinations that will help you access quality, low-cost medicines within your Plan. This process first uses an independent P&T committee of pharmacists and Physicians that evaluate the clinical evidence of each product under review. During the second step of the process, a committee composed of members with various expertise combines the clinical review with an in-depth analysis of market dynamics, Member impact and financial value to make determinations about 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 our behalf. Our PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. Our PBM, in consultation with us, 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 University has purchased, which is described in this Booklet. The Plan Year means the period of time by which the University renews its Group Blanket Master Contract with us.

Precertification

Please see the section “Getting Approval for Benefits” for details.

Premium

The amount that you must pay to be covered by this Plan. This may be based on your age and will depend on the University’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 that are required by law, or as otherwise determined by us to be Medically Necessary.
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.

Primary Care Provider

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

Provider

A professional or Facility licensed 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/individual-commercial/join-our-network. 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. Provider does not include a Student Health Center or University Health Services provider.] If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Qualifying Payment Amount

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

Recognized Amount

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

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

- For all other Surprise Billing Claims, the Recognized Amount is the 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.

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 Facility that gives limited basic health care services to Members on a "walk-in" basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

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

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

Student

A student who is eligible for and has enrolled in the Plan according to the rules stated under the "Eligibility" section.

Surprise Billing Claim

Please refer to the "Consolidated Appropriations Act of 2021 Notice" and the "Indiana Surprise Billing Law Notice" at the front of this Booklet for details.

University or School

The educational institution which has a Group Blanket Master Contract with us, Anthem Insurance Companies, Inc., and which sponsors this Plan.

Urgent Care Center

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

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.