Benefit Booklet

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

University of Kentucky Student Health Plan

08-15-2025

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

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

Plan Administered By:

Anthem Health Plans of Kentucky, Inc.

13550 Triton Park Boulevard
Louisville, KY 40223

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Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

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

Surprise Billing Claims

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

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

No Surprises Act Requirements

Emergency Services

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

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

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

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

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

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. However, if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges, claims will be paid at the Out-of-Network benefit level. This means you will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This Notice and Consent process described below does not apply to Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility. Your Out-of-Pocket costs for claims for Covered Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility will be limited to amounts that would apply if the Covered 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:

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

Out-of-Network Air Ambulance Services

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

How Cost-Shares Are Calculated

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

Appeals

If you receive Emergency Services from an Out-of-Network Provider 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 Surprises Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the “Complaint and Appeals Process” 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.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

Additional Federal Notices

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

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

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

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

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

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

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

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

Mental Health Parity and Addiction Equity Act

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

Special Enrollment Notice

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

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

Introduction

Welcome to Anthem!

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

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.

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

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. Please see these definitions for the best understanding of what is being stated. Throughout this Booklet you will also see references to “we,” “us,” “our,” “you,” and “your.” The words “we,” “us,” and “our” mean the Claims Administrator. The words “you” and “your” mean the Member, 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 the Claims Administrator’s website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips.

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

How to Get Language Assistance

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

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Schedule of Benefits

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you 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.

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

To get the maximum benefits at the lowest Out-of-Pocket cost, you must get Covered Services from a Tier 1 In-Network Preferred Provider. Covered Services received from any other In-Network Provider are covered at Tier 2 In-Network level and often require a higher Copayment / Coinsurance. Services which are not received from a Tier 1 or Tier 2 Provider will be considered a Tier 3 Out-of-Network service, unless otherwise specified in this Booklet.

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

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

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

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

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

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

Benefit Period	Plan Year
Dependent Age Limit	To the end of the month in which the child attains age 26.

Deductible	**(Tier 1) Preferred Provider (UK HealthCare Providers)**	**(Tier 2) In-Network Providers**	**(Tier 3) Out-of-Network**
Per Member	$300	$500	$1,000

Note: The Tier 1 and Tier 2 Deductibles are combined and accumulate toward each other, but the Tier 3 Deductible is separate.

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 the following benefits:
- Services from the University Health Services (UHS).

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

Coinsurance	**(Tier 1) Preferred Provider (UK HealthCare Providers)**	**(Tier 2) In-Network Providers**	**(Tier 3) Out-of-Network**
Plan Pays	75%	60%	45%
Member Pays	25%	40%	55%

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	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
Per Member	$6,500	$13,000	
Per Family All other Members combined	$13,000	$26,000	

The Tier 1 and Tier 2 Out-of-Pocket Limit is combined, but the Tier 3 Out-of-Pocket Limit is separate.

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 the following benefits:

- Services listed under "Vision Services for Members Age 21 and Older"
- Out-of-Network Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services.

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

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

Important Notice about Your Cost Shares

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

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 dialysis 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	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
Allergy Services	Benefits are based on the setting in which Covered Services are received.		

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
Ambulance Services (Ground, Air and Water) Emergency Services	Not covered	40% Coinsurance after Deductible	
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.			
Ambulance Services (Ground, Air, and Water) Non-Emergency Services	Not covered	40% Coinsurance after Deductible	
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:** All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details. Benefits for non-Emergency ground or water ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used. The limit does not apply to air ambulance services.			
Autism Services	Benefits are based on the setting in which Covered Services are received.		
Cardiac Rehabilitation	See "Therapy Services."		
Chemotherapy	Benefits are based on the setting in which Covered Services are received.		
Chiropractor Services	See "Therapy Services."		
Clinical Trials	Benefits are based on the setting in which Covered Services are received.		
Congenital Defects and Birth Abnormalities	Benefits are based on the setting in which Covered Services are received.		

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
Dental Services For Members Through Age 20 **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. Each Member must pay a Deductible of $500 per Benefit Period for the dental services below. This Deductible is separate and does not apply toward any other Deductible for Covered Services in this Plan.			
• Diagnostic and Preventive Services	35% Coinsurance	50% Coinsurance	50% Coinsurance
• Basic Restorative Services	35% Coinsurance	50% Coinsurance	50% Coinsurance
• Endodontic Services	35% Coinsurance	50% Coinsurance	50% Coinsurance
• Periodontal Services	35% Coinsurance	50% Coinsurance	50% Coinsurance
• Oral Surgery Services	35% Coinsurance	50% Coinsurance	50% Coinsurance
• Major Restorative Services	35% Coinsurance	50% Coinsurance	50% Coinsurance
• Prosthodontic Services	35% Coinsurance	50% Coinsurance	50% Coinsurance
• Dentally Necessary Orthodontic Care	35% Coinsurance	50% Coinsurance	50% Coinsurance
Dental Services (All Members / All Ages) (Limited to services for accidental injury, for certain Members requiring hospitalization or general anesthesia, or to prepare the mouth for certain medical treatments) Coverage also includes removal of impacted wisdom teeth.	Benefits are based on the setting in which Covered Services are received.		
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under “Preventive Care.” Benefits for diabetic education are based on the setting in which Covered Services are received.	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	55% Coinsurance after Deductible

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
Diagnostic Services			
• Reference Labs	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• All Other Diagnostic Services	Benefits are based on the setting in which Covered Services are received.		
Dialysis	Benefits are based on the setting in which Covered Services are received.		
Durable Medical Equipment (DME), Medical Devices, and Supplies	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
Prosthetics	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
Orthotics	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
Medical Supplies	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
The cost-shares listed above apply when your Provider submits separate bills for the equipment or supplies.			
Hearing Aid Benefit Maximum	One hearing aid per ear every 36 months for children 18 years of age or under In- and Out-of-Network combined. Coverage is limited to $3,000 per hearing aid.		
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, hearing aids and wigs will be based on the Maximum Allowed Amount for a standard item that is Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and you will be required to pay any costs that exceed the Maximum Allowed Amount. Please check with your Provider or contact us if you have questions about the Maximum Allowed Amount.			

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
Emergency Room Services			
Emergency Room			
• Emergency Room Facility Charge	$200 Copayment per visit then 25% Coinsurance after Deductible Copayment waived if admitted		
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon)	25% Coinsurance Deductible Does Not Apply		
• Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	25% Coinsurance Deductible Does Not Apply		
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	25% Coinsurance Deductible Does Not Apply		
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	25% Coinsurance Deductible Does Not Apply		
As described in the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet, for Emergency Services Out-of-Network Providers may only bill you for any applicable Copayments, Deductible and Coinsurance and may not bill you for any charges over the Plan’s Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable and followed the notice and consent process. Please refer to the Notice at the beginning of this Booklet for more details.			
Gene Therapy Services	Benefits are based on the setting in which Covered Services are received.		
• Precertification required			

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
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)	Not Applicable	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Home Dialysis	Not Applicable	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Home Infusion Therapy / Chemotherapy	Not Applicable	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Specialty Prescription Drugs for Infusion/Injection – Other than Chemotherapy	Not Applicable	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Other Home Health Care Services / Supplies	Not Applicable	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Private Duty Nursing (including continuous complex skilled nursing services)	Not Applicable	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Home Care Benefit Maximum	100 visits per Benefit Period In- and Out-of-Network combined The limit does not apply to Home Infusion Therapy or Home Dialysis.		
• Private Duty Benefit Maximum	250 visits per year In- and Out-of-Network combined.		
Home Infusion Therapy	See “Home Health Care.”		
Hospice Care			
• Home Hospice Care	Not covered	40% Coinsurance after Deductible	55% Coinsurance after Deductible

Benefits		(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
• Bereavement	Not covered	40% Coinsurance after Deductible	55% Coinsurance after Deductible	
• Inpatient Hospice	Not covered	40% Coinsurance after Deductible	55% Coinsurance after Deductible	
• Outpatient Hospice	Not covered	40% Coinsurance after Deductible	55% Coinsurance after Deductible	
• Respite Care	Not covered	40% Coinsurance after Deductible	55% Coinsurance after Deductible	
This Plan's Hospice benefit will meet or exceed Medicare's Hospice benefit. If you use an Out-of-Network Provider, that Provider may also bill you for any charges over Medicare's Hospice benefit.				
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		25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Skilled Nursing Facility		25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Rehabilitation		25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program) Benefit Maximum		Unlimited		
• Mental Health / Substance Use Disorder Facility		25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
• Residential Treatment Center	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Ancillary Services	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
Doctor Services when billed separately from the Facility for:			
• General Medical Care / Evaluation and Management (E&M)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Surgery	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Maternity	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Services	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
Maternity and Reproductive Health Services			
• Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Inpatient Services (Delivery)	See "Inpatient Services."		
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	See "Therapy Services."		

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) 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.			
• University Health Services (UHS).	No Copayment, Deductible, or Coinsurance	Not Applicable	Not Applicable
• Primary Care Physician / Provider (PCP)	$25 Copayment per visit	$30 Copayment per visit	55% Coinsurance after Deductible
• Mental Health and Substance Use Disorder Provider (Including In-Person and/or Virtual Visits)	In-Person Visits: $25 Copayment per visit Virtual Visits: $25 Copayment per visit	In-Person Visits: $30 Copayment per visit Virtual Visits: $30 Copayment per visit	55% Coinsurance after Deductible
• Specialty Care Physician / Provider (SCP) (including SCP Online Visits)	$45 Copayment per visit	$50 Copayment per visit	55% Coinsurance after Deductible
• Retail Health Clinic Visit	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Virtual Visits from our Online Provider, LiveHealth Online (whether accessed Directly or through our mobile app) – Includes Mental Health & Substance Use Disorder Virtual Visits	Not Applicable	$25 Copayment per visit	Not covered
• Counseling – Includes Family Planning and Nutritional Counseling (Other Than Eating Disorders	$25 Copayment per visit	$30 Copayment per visit	55% Coinsurance after Deductible

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
• Nutritional Counseling for Eating Disorders	$25 Copayment per visit	$30 Copayment per visit	55% Coinsurance after Deductible
• Allergy Testing	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Diagnostic X-ray	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Office Surgery (including anesthesia)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Therapy Services:			
– Chiropractic / Osteopathic / Manipulative Therapy*	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit
– Physical Therapy*	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
– Speech Therapy	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit
– Occupational Therapy*	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit
– Dialysis	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit
– Cardiac Rehabilitation	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit
– Pulmonary Therapy	$45 Copayment per visit	$50 Copayment per visit	55% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.			
*If you get Covered Services from a Chiropractor, you will not have to pay a Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician. If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay a Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician for an office visit.			
• Prescription Drugs Administered in the Office (other than allergy serum)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
Orthotics	See “Durable Medical Equipment (DME), Medical Devices, and Supplies.”		
Outpatient Facility Services			
• Facility Surgery Charge	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Facility Surgery Lab	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
• Facility Surgery X-ray	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Ancillary Services	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Doctor Surgery Charges	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Allergy shots / Injections (including allergy serum)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Diagnostic Lab	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
• Diagnostic X-ray	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Other Diagnostic Tests: (EKG, EEG, etc.)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Therapy:			
– Chiropractic / Osteopathic / Manipulative Therapy*	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit
– Physical Therapy*	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit
– Speech Therapy *	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit
– Occupational Therapy	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit
– Radiation / Chemotherapy / Respiratory Therapy	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
– Dialysis	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
– Cardiac Rehabilitation	$15 Copayment per visit	$15 Copayment per visit	$15 Copayment per visit
– Pulmonary Therapy	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.			

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
*****If you get Covered Services from a Chiropractor, you will not have to pay an outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician. If you get Covered Services from a Physical Therapist or Occupational Therapist, you will not have to pay an outpatient Facility Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician for an office visit.			
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
Physical Therapy	See “Therapy Services.”		
Preventive Care	No Copayment, Deductible, or Coinsurance	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Prosthetics	See “Durable Medical Equipment (DME), Medical Devices, and Supplies.”		
Pulmonary Therapy	See “Therapy Services.”		
Radiation Therapy	Benefits are based on the setting in which Covered Services are received.		
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	Benefits are based on the setting in which Covered Services are received.		
Skilled Nursing Facility	See “Inpatient Services.”		
Speech Therapy	See “Therapy Services.”		

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
Surgery	Benefits are based on the setting in which Covered Services are received.		
Telemedicine			
• Primary Care Physician / Provider (PCP)	Not Applicable	$25 Copayment per visit	Not covered
• Specialty Care Physician / Provider (SPC)	Not Applicable	$25 Copayment per visit	Not covered
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)	Unlimited Visits per Benefit Period		
• Physical Therapy (Habilitative)	Unlimited Visits per Benefit Period		
• Occupational Therapy (Rehabilitative)	Unlimited Visits per Benefit Period		
• Occupational Therapy (Habilitative)	Unlimited Visits per Benefit Period		
• Speech Therapy (Rehabilitative)	Unlimited Visits per Benefit Period		
• Speech Therapy (Habilitative)	Unlimited Visits per Benefit Period		
• Post-Cochlear Implant Aural Therapy	30 visits per Benefit Period		
• Cognitive Rehabilitation Therapy	20 visits per Benefit Period		

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
• Manipulation Therapy	24 visits per Benefit Period		
• Pulmonary Rehabilitation	12 visits per Benefit Period		
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit. **Note:** The limits for physical, occupational and speech therapy will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit, including Autism Services. **Note:** When you get pulmonary rehabilitation in the home, the Home Health Care Visit limit will apply instead of the Therapy Services limits listed above. **Note:** If pulmonary rehabilitation is given as part of physical therapy, the Physical Therapy (Rehabilitative) limit will apply instead of the Pulmonary Rehabilitation limit. **Note:** Prior Authorization is required for rehabilitation, and habilitation services for as physical, occupational, speech, and cardiac therapy. Visits will be approved based on medical necessity. Visits applies to In-Network and Out-of-Network Providers combined.			
Transplant Services	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."		
Urgent Care Services (Office and Home* Visits) *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section.			
• Urgent Care Visit Charge	$75 Copayment per visit	$75 Copayment per visit	55% Coinsurance after Deductible
• Allergy Testing	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
• Diagnostic Lab (i.e., other than reference labs)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Diagnostic X-ray	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
• Office Surgery (including anesthesia)	$75 Copayment per visit	$75 Copayment per visit	55% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (other than allergy serum)	25% Coinsurance after Deductible	40% Coinsurance after Deductible	55% Coinsurance after Deductible
If you get urgent care at a Hospital or other outpatient Facility, please refer to “Outpatient Facility Services” for details on what you will pay.			
Vision Services For Members Through Age 20 **Note:** To get the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding a Blue View Vision Provider, please call us at the number on the back of your ID card. Out-of-Network Providers may bill you for any charges that exceed the Plan’s Maximum Allowed Amount.			
• Routine Eye Exam Limited to one exam per Benefit Period.	$20 Copayment	Not covered	Not covered
• Standard Plastic Lenses Limited to one set of lenses per Benefit Period per Member. One set of replacement lenses is also covered if Medically Necessary.			

Benefits		(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
Single Vision		$40 Copayment	Not Applicable	Not covered
Bifocal		$40 Copayment	Not Applicable	Not covered
Trifocal		$40 Copayment	Not Applicable	Not covered
Lenticular		$40 Copayment	Not Applicable	Not covered
Note: Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic lenses at no additional cost when received In-Network.				
• Frames				
- Limited to one frame from the Anthem formulary per Benefit Period per Member. One replacement frame is also covered if Medically Necessary.				
- Retail cost up to $130	No Copayment, Deductible or Coinsurance	Not Applicable	Not covered	
- Retail cost up to $130-$160	$15 Copayment	Not Applicable	Not covered	
- Retail cost up to $160-$200	$30 Copayment	Not Applicable	Not covered	
- Retail cost up to $200-$250	$50 Copayment	Not Applicable	Not covered	
- Retail cost greater than $250	60% Coinsurance	Not Applicable	Not covered	
• Contact Lenses Elective or non-elective contact lenses from the Anthem formulary are covered once per Benefit Period per Member. Benefits include a contact lens fitting and evaluation once per Benefit Period per Member.				
- Elective Contact Lenses (Conventional or Disposable) – 12-month supply		15% off price after $130 allowance	Not Applicable	Not covered
- Non-Elective Contact Lenses – 12-month supply		$40 Copayment	Not Applicable	Not covered

Benefits	(Tier 1) Preferred Provider (UK HealthCare Providers)	(Tier 2) In-Network Providers	(Tier 3) Out-of-Network
- Contact Lens Fitting and Evaluation	$40 Copayment	Not Applicable	Not covered
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.			
Vision Services For Members Age 21 and Older **Note:** To get the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding a Blue View Vision Provider, please call us at the number on the back of your ID card. Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.			
• Routine Eye Exam Limited to one exam per Benefit Period.	$20 Copayment	Not Applicable	Not covered
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.		
If you get Covered Services from an Optometrist, you will not have to pay a Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician.			

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

standards for care delivery.

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

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

The requirements described below do not apply to the following:

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

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

	In-Network Transplant Provider	**Out-of-Network Transplant Provider**
Transplant Benefit Period	Starts one day before a Covered solid organ Transplant Procedure and one day before high dose chemotherapy or preparative regimen for a covered bone marrow/stem cell transplant and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts the day of a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.
Inpatient Facility Services • **Precertification required**	During the Transplant Benefit Period: 40% Coinsurance after Deductible.	During the Transplant Benefit Period. You will pay 55% Coinsurance after Deductible. During

	Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will **not** have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you **will** have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.
Inpatient Professional and Ancillary (non-Hospital) Services	40% Coinsurance after Deductible.	55% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Outpatient Facility Services**	40% Coinsurance after Deductible.	55% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.

• **Outpatient Facility Services**	40% Coinsurance after Deductible.	55% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Transportation and Lodging**	40% Coinsurance after Deductible.	Not Covered
• **Transportation and Lodging Limit**	Covered, as approved by us, up to $10,000 per transplant In-Network only. Benefits are not available Out-of-Network.	
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	40% Coinsurance after Deductible.	55% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Donor Search Limit**	Covered, as approved by us, up $30,000 per transplant In- and Out-of-Network combined.	
Live Donor Health Services		
• **Inpatient Facility Services**	40% Coinsurance after Deductible.	55% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Outpatient Facility Services**	40% Coinsurance after Deductible.	55% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
• **Donor Health Service Limit**	Medically Necessary charges for getting an organ from a live 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.	

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 complete authority to decide the Medical Necessity of the service. If you disagree with the Plan's determination, you have the right to file an appeal as described in the "Your Right to Appeal" section.

This Plan includes three (3) levels of coverage:

- **Tier 1 Network Providers (UK HealthCare Providers)** contract with the Plan and charge a lower Copayment / Coinsurance on many services than other In-Network Providers.
- **Tier 2 All other Network Providers** are also In-Network but may require a higher Copayment/Coinsurance on many services than Tier 1 In-Network Provider.
- **Out-of-Network Providers** are not in the Plan's Network and require the highest Copayment / Coinsurance in this Booklet.

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.

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.

Preferred Facilities

This Plan has two types of In-Network Providers at Inpatient or Outpatient Facilities, plus Out-of-Network Providers:

- **In-Network Preferred Facilities** contract with us and charge a lower Copayment / Coinsurance on many services than other In-Network Providers.
- **All other In-Network Provider Facilities** are also In-Network but require a higher Copayment/Coinsurance on many services than Preferred Facilities.
- **Out-of-Network Provider Facilities** are not In-Network and require the highest Copayment / Coinsurance in this Plan.

Out-of-Network Services

When you do not use a Tier 1 or Tier 2 In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Tier 3 Out-of-Network level, unless otherwise indicated in this Booklet.

For services from a Tier 3 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;

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

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

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

5. You may have to file claims; and

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

Surprise Billing Claims

Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 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.

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.

If an Out-of-Network Provider meets our enrollment criteria and is willing to meet the terms and conditions of our Provider agreement, that Provider has the right to become an In-Network Provider for this Plan. They will not become an In-Network Provider, however, until they have signed the required Provider agreement.

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

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 process described in “Your Right to Appeal.” Continuity of care under this section will end the earlier of completion of treatment, 90 days after the effective date of termination or non-renewal, nine months if you have been diagnosed with a terminal illness at the time of termination, or in the case of pregnancy, six weeks following delivery.

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

The Plan 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/setting/place of care will not be Medically Necessary if they are given in a higher level of care/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:

- 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 imagining 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. Anthem, on behalf of the University, may decide that a service that was asked for is not Medically Necessary if you have not tried other clinically equivalent treatments that are more effective 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 it is determined that your services are Medically Necessary. For benefits to be covered, on the date you get service:

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

Types of Reviews

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

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

  For admissions following Emergency Care, you, your authorized representative or Doctor must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time. For

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

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

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

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

Who is Responsible for Precertification?

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

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	• 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.

Provider Network Status	Responsibility to Get Precertification	Comments
		• **BlueCard Providers must obtain precertification for all Inpatient Admissions.**
NOTE: For an Emergency Care admission, precertification is not required. However, you, your authorized representative or Doctor must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.		

How Decisions are Made

We, on behalf of the University, 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, on behalf of the University, to review and update these clinical coverage guidelines from time to time.

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

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

Decision and Notice Requirements

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

Request Category	Timeframe Requirement for Decision and Notification
Urgent Pre-Service Review	24 hours from the receipt of all necessary information
Non-Urgent Pre-Service Review	5 calendar 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	24 hours from the receipt of all necessary information
Non-Urgent Continued Review for ongoing outpatient treatment	5 calendar days from the receipt of all necessary information
Post-Service Review	5 calendar days from the receipt of all necessary information

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 or if the information is not complete by the required timeframe, we will make a decision based upon the information we have.

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

Important Information

On behalf of the University, 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 the Plan's 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 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.

Health Plan Individual Case Management

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

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

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

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

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

benefits or approving alternate care. In such case, the Plan will notify you or your authorized representative in writing.

What's Covered

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

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

You should also know that many Covered Services can be received in several settings, including a Doctor's office or your home, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. **For services to be covered, they must be provided in the lowest level of care that is medically appropriate.** The costs of services will often vary depending on the setting and from whom you choose to get Covered Services, and the choice of setting can result in a change in the amount you need to pay or even in a denial for the services. Please see the "Schedule of Benefits" and the "Getting Approval for Benefits" sections 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.

And one or more of the following criteria are met:

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

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

Ambulance services are subject to Medical Necessity reviews by the Plan. 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 the Plan. 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. If applicable to your Plan, 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 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.**

Autism Spectrum Disorder Services

Your Plan also covers the diagnosis and treatment of Autism Spectrum Disorders. Autism Spectrum Disorders are a physical, mental, or cognitive illness or disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). They include any of the pervasive developmental disorders, Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Benefits for Members diagnosed with an Autism Spectrum Disorder include the following:

1. Medical care from by a licensed Provider.

2. Habilitative or rehabilitative care. These include counseling and guidance services, therapy, treatment programs, and applied behavior analysis.

3. Prescription Drugs from a Retail or Home Delivery (Mail Order) Pharmacy, if this Plan includes Pharmacy benefits, and Medically Necessary services to determine the need or effectiveness of the Drugs.

4. Psychiatric care.

5. Psychological care given by a licensed Provider.

6. Therapy from licensed speech therapists, occupational therapists, or physical therapists;

7. Applied behavior analysis prescribed or ordered by a licensed Provider; and

8. Access to autism liaison services. For more information regarding these services, please contact Member Services on the back of your ID Card.

No benefits are available under this section for services, supplies, or equipment:

1. For which the Member has no legal obligation to pay in the absence of this or like coverage;
2. Given to the Member by a publicly funded program;
3. Given by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; and
4. For services given by people who are not licensed as required by law.
5. For treatments of sexual dysfunction and feeding disorders as listed in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
6. For treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental / Investigational.
7. For tuition or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
8. For learning, motor skills and primary communication disorders, as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association and which are not a part of Autism Spectrum Disorder.
9. For treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.
10. For the diagnosis or treatment of mental illness that, in Anthem's reasonable judgment, are any of the following:
    a. Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
    b. Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and are therefore considered Experimental / Investigational.
    c. Not consistent with the Anthem's level of care guidelines or best practices, as modified from time to time.
    d. Not clinically appropriate for the Member's condition based on generally accepted standards of medical practice and benchmarks.

Behavioral Health Services

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

Biomarker Testing Services

This Plan provides coverage for biomarker testing when ordered by a Qualified Health Care 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 supported by medical and scientific evidence, including but not limited to:

a) Labeled indications from an FDA-approved or cleared test;
b) Indicated tests for an FDA-approved Drug;
c) Warnings and precautions on FDA-approved Drug labels;
d) Centers for Medicare and Medicaid Services national coverage determinations;
e) Medicare Administrative Contractor local coverage determinations;
f) Nationally recognized clinical practice guidelines; or
g) Consensus statements.

Breast Cancer Treatment

This Plan covers services to treat breast cancer including chemotherapy, high-dose chemotherapy with autologous bone marrow transplants or stem cell transplants, mastectomies, prosthetics, and reconstructive services needed after the mastectomy. Please see the rest of the Booklet for details on how each benefit is covered.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Chiropractor Services

Please see "Therapy Services" later in this section.

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.

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

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

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

   i. The Department of Veterans Affairs.

   ii. The Department of Defense.

   iii. The Department of Energy.

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

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

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

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

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

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

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

Congenital Defects and Birth Abnormalities

Covered Services include the treatment of medically-diagnosed congenital defects and birth abnormalities.

Dental Services

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. Also, services for tooth reimplantation will be covered if Medically Necessary.

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 the Plan. When you go out of network, you may have to pay up front — then you'll submit claims to the Plan for reimbursement.

For help finding a dentist in your network, log in to 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.

Timely Access to Care

You may choose the *dentist* you want for your dental care. However, your choice of *dentist* can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your *dentist* is a N*on-Participating Dentist*. There may be differences in the payment amount between a *Participating Dentist* and a *Non-Participating Dentist*.

In some circumstances, we may authorize the *Participating Dentist* coinsurance (for Deductible and covered dental services) to apply for Covered Services that you receive from a *Non-Participating Dentist*.

Circumstances such as:

- A *Participating Dentist* isn't available as referenced with this Booklet;
- You receive Emergency Care and are not able to reach your *Participating Dentist* or us prior to receiving care; or
- A participating general *dentist* that accepts your plan and new patients is not within thirty (30) minutes travel time or thirty (30) miles from your residence or your place of employment.

You or your *dentist* must contact us in advance of receiving the *Covered Service*. When you get our proper approval, these services are called **authorized referral services**. When you **do not** get an authorized referral from us, the *Non-Participating* Coinsurance will apply and you may be responsible for the difference between the *Non-Participating Dentist's* charges and the Maximum Allowed Amount. Therefore, it is important to contact us prior to *Covered Services* being received from a *Non-Participating Dentist* to ensure you understand all of your out-of-pocket costs. The toll-free number to call for prior approval is the number listed on your Member *Identification Card*.

If you receive an authorized referral or preauthorization from us for a *Non-Participating Dentist* due to Provider network adequacy issues, you will be responsible for the In-Network Coinsurance portion along with any applicable limits and exclusion that would normally apply when receiving treatment from an In-Network dentist.

It is important that if you move your residence or your place of employment more than thirty (30) minutes travel time or thirty (30) miles from *Participating Dentist*(*s*) who accept your plan, you may notify Anthem in writing or call our Customer Service to request a Provider directory or assistance in finding another *Participating Dentist* or Provider office that is located within thirty (30) minutes travel time or thirty (30) miles of your new residence or place of employment. Anthem must be notified within thirty-one (31) days of your move in order to ensure timely access to services near you.

Pretreatment Estimate

When you need major dental care, like crowns, root canals, dentures/bridges, oral surgery, or braces — it is 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 Services For Members Through Age 20

The following dental care services are covered for Members until the end of the month in which they turn 21. All Covered Services are subject to the terms, limitations, and exclusions of this Plan.

Diagnostic and Preventive Services

Oral Exams Covered 2 times per 12 months. The following types of oral exams are covered:

- Periodic oral exam- a routine dental exam to check in on your dental health; and
- Oral Exam for children under 3 years of age.

Radiographs (X-rays)

- Bitewings (including vertical) – 2 sets of 4 films per 12-month period.
- Vertical bitewings – 2 sets of 7-8 films per 12 month period.
- Periapical (Intra/Extraoral) – 2 per 12-month period.
- Intraoral occlusal film – 2 films per 12 month period.
- Extra-oral – 2D projection radiographic image created using a stationary radiation source and detector – 2 films per 12 month period.
- Full Mouth (also called Complete Series) or Panoramic film – Once per 12-month period.

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 or fluoride varnish) – Covered 2 times per12 months.

Sealants Covered once per 36 months for permanent first and second molars.

Space Maintainers Covered 2 times per 12-month period. Includes all adjustments within 6 months of installation.

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

Basic Restorative Services

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

- **Amalgam** These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.

- **Composite Resin** These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If you choose to have a composite resin filling placed on a back tooth, the Plan will pay up to the Maximum Allowed Amount for an amalgam restoration. You will be responsible to pay the difference if the dentist charges more, plus any applicable Deductible and/or Coinsurance.

Resin based composite resin crown, anterior.

Brush Biopsy.

Pin retention Covered once per 60 months

Basic Extractions

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

Endodontic Services

Endodontic Therapy

- Therapeutic pulpotomy. Covered on primary teeth. Will not be covered if given with root canal therapy.
- Pulpal therapy (anterior and posterior) primary teeth only.
- Partial pulpotomy for apexogenesis. Covered once per tooth per lifetime. Permanent Tooth Only.
- Root canal therapy. Covered on permanent teeth. Covered once per tooth per lifetime.

Periodontal Services

Periodontal Scaling and Root Planing This is a non-surgical periodontal service to treat diseases of the gums (gingiva) and bone that supports the teeth. Covered once per quadrant per 12 months.

Periodontal Maintenance Covered twice per 12 months.

Complex Surgical Periodontal Care These services are surgical treatment for diseases of the gums (gingiva) and bone that supports the teeth.

- Surgical Revision per tooth

The following surgical periodontal care is covered once per quadrant per 12 months:

- Gingivectomy / gingivoplasty
- Anatomical crown exposure
- Gingival flap procedure
- Osseous Surgery

The following surgical periodontal care is covered once per tooth or range of teeth or tooth site per 12 months:

- Apically positioned flap
- Crown lengthening
- Bone replacement graft- per site
- Pedicle soft tissue graft, autogenous and non-autogenous connective tissue graft and free soft tissue graft
- Distal/proximal wedge

Oral Surgery Services

Complex Surgical Extractions

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

Other Oral Surgery Procedures Below is a listing of common oral surgery procedures that are submitted for claims payment. Additional oral surgery procedures are covered under this Plan. Your Dentist can send us a Pretreatment Estimate should you require additional information regarding the costs associated with the additional covered oral surgery services.

- Surgical exposure of impacted or unerupted tooth for orthodontic reasons
- Mobilization to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Alveoplasty
- Incision and drainage of abscess, intraoral and extraoral and
- Frenulectomy

Adjunctive General Services

Intravenous Conscious Sedation Covered with complex surgical services.

General Anesthesia – Covered when deemed clinically necessary.

Major Restorative Services

Pre-fabricated or Stainless Steel Crown Covered once tooth per 60 months.

Onlays and/or Permanent Crowns To be covered the permanent tooth must have extensive loss of natural tooth structure due to decay or fracture so that a restoration (such as a filling or inlay) cannot be used to restore the tooth. Covered once per tooth per 60 months.

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

Gold Foil Restorations Gold foil restorations are covered at the same frequency as an amalgam filling. Gold foil restorations will be paid up to the same Maximum Allowed Amount for an amalgam filling. You’re responsible to pay for any amount over the Maximum Allowed Amount, plus any applicable Deductible and Coinsurance.

Inlay Restorations Covered once per tooth per 60 months.

Recement an inlay, onlay or crown Covered 6 months after initial placement.

Recement cast or prefabricated post and core Covered 6 months after placement.

Core buildup, including pins Covered once per tooth per 60 months.

Cast and prefabricated post and core Covered once per tooth per 60 months.

Additional procedure to construct new crown under existing partial framework Covered once per 60 months.

Prosthodontic Services

Dentures and Partials (Removable Prosthodontic Services) Covered once per 60 months. The Plan will pay for either a complete or immediate complete denture per arch but not both.

Occlusal guard, hard and soft appliance - Covered one time per 12 months ages 13 and older.

Denture Repair - Covered once per 6 months after 12 months has passed since the initial placement of the appliance.

Denture and Partial Adjustments Covered once per 6 months after 6 months has passed since the initial placement of the appliance.

Repairs, Replacement of Missing or Broken Artificial Teeth, Replacement of Broken Clasps Covered once per 6 months after 12 months has passed from the initial placement of the appliance.

Add tooth and clasp to existing partial denture (per tooth).

Replace all Teeth and Acrylic for Complete and Partial Dentures.

Rebase and Reline Covered once per 12 months after 6 months has passed since the initial placement of the appliance.

Tissue Conditioning.

Overdentures (Complete and Partial Upper and Lower) The Plan will pay up to the Maximum Allowed Amount for an upper and lower complete denture or partial denture. If you still choose to have an overdenture, you will have to pay the difference any Deductible and/or Coinsurance for the covered benefit.

Bridges (Fixed Prosthodontic Services) Covered once per 60 months.

Bridge Repair Covered once per 6 months after 6 months. Limited to repair(s) performed more than 12 months after the initial insertion.

Recement Bridge Covered once per 12 months after 6 months from the initial placement of the appliance.

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

Implant Services All implant services listed below are covered once per 60 months:

- Surgical placement of implant body including enosteal, eposteal and transosteal implants
- Interim implant body
- Interim, prefabricated and sutom implant abutments
- Recement implant/abutment supported crown and fixed partical denture (bridge)
- Implant maintenance procedure
- Repair of implant supported prosthesis
- Replacement of semi precision or precision attachment of implant supported prosthesis.
- Implant removal and broken implant retaining screw
- Debridement and osseous contouring of a peri-implant defect
- Bone graft for repair of a peri-implant defect
- Radiographic/surgical implant index

Maxillofacial Prosthetics:

The following services shall be covered if provided by a board certified prosthodontist:
(1) A nasal prosthesis;
(2) An auricular prosthesis;
(3) A facial prosthesis;
(4) A mandibular resection prosthesis;
(5) A pediatric speech aid;
(6) An adult speech aid

(7) A palatal augmentation prosthesis;
(8) A palatal lift prosthesis;
(9) An oral surgical splint; or
(10) An unspecified maxillofacial prosthetic.

Orthodontic Care

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

Dentally Necessary Orthodontic Care This Plan will only cover orthodontic care when it is dentally necessary. Dentally necessary criteria is described below these orthodontic limitations:

- Space maintainers and appliance therapy shall not be covered in conjunction with comprehensive orthodontics.
- The Plan shall only cover new orthodontic brackets or appliances.
- Removable and fixed appliance therapy for harmful habits is covered.
- Surgical exposure of impacted or unerupted tooth for orthodontic reasons is covered
- Placement of device to facilitate eruption of impacted tooth is covered.

A comprehensive orthodontic service shall:

a) Require a referral by a *dentist*; and
b) Be limited to:
    1. The correction of a disabling malocclusion; or
    2. Transitional or full permanent dentition unless for treatment of a cleft palate or severe facial anomaly.

A disabling malocclusion shall exist if a patient:

A. Has a deep impinging overbite that shows palatal impingement of the majority of the lower incisors

B. Has a true anterior open bite that does not include:

    1. One or two teeth slightly out of occlusion
    2. Where the incisors have not fully erupted

C. Demonstrates a significant antero-posterior discrepancy (class II or III malocclusion that is comparable to at least one full tooth class II or III, dental or skeletal)

D. Has an anterior crossbite that involves:

    1. More than two teeth in crossbite
    2. Obvious gingival stripping
    3. Recession related to the crossbite

E. Demonstrates handicapping posterior transverse discrepancies which:

    1. May include several teeth, one of which must be a molar
    2. Is handicapping in function as follows:
        i. Functional shift
        ii. Facial asymmetry
        iii. Complete buccal or lingual crossbite
        iv. Speech concern

F. Has significant posterior open bite that does not involve:

   1. Partially erupted teeth
   2. One or two teeth slightly out of malocclusion

G. Has impacted teeth that will not erupt into the arches without orthodontic or surgical intervention (does not apply to third molars)

H. Has extreme overjet in excess of 8 to 9 millimeters and one of the skeletal conditions specified in provisions A through G of this section

I. Has trauma or injury resulting in severe misalignment of the teeth or alveolar structures, and does not include simple loss of teeth with no other affects

J. Has a congenital or developmental disorder giving rise to a handicapping malocclusion

K. Has a significant facial discrepancy requiring a combined orthodontic and orthognathic surgery treatment approach

L. Has developmental anodontia in which several congenitally missing teeth result in a handicapping malocclusion or arch deformation

What Orthodontic Care Does NOT Include:

1. Monthly treatment visits that are billed separately – these costs should already be included in the cost of treatment.
2. Orthodontic retention or retainers that are billed separately – these costs should already be included in the cost of treatment.
3. Retreatment and services given due to a relapse;
4. Inpatient or outpatient hospital expenses, unless covered by the medical benefits of this Plan.
5. Repair of orthodontic appliances such as functional appliances, palatal expanders, removable and fixed retainer;
6. Replacement of lost or broken retainer.
7. Cephalometric x-rays that are billed separately. They are included in the cost of orthodontic records for orthodontic treatment.

How Orthodontic Care is Paid.

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

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

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

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.

Other Dental Services

The Plan will also cover Medically Necessary Hospital or Ambulatory Surgery Center charges and anesthesia for dental care if the Member is:

1. Under the age of 20,
2. Has a serious mental or physical condition; or
3. Has significant behavioral problems.

The Member's Provider must certify that hospitalization or general anesthesia is required to safely and effectively give the dental care. Benefits do not include routine dental care or treatment of dental conditions not covered by the Plan.

Diabetes Equipment, Education, and Supplies

Benefits are available for medical services, supplies, equipment, insulin, and Prescription Drugs needed to treat diabetes. Covered Services also include diabetic self-management training and education programs, including medical nutrition therapy.

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 the Plan.

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms

- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

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

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

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

Dialysis

Please see “Therapy Services” later in this section.

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

Durable Medical Equipment and Medical Devices

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

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

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by the Plan. 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.

Orthotics may only be replaced once per year, when Medically Necessary. However, additional replacements will be allowed:

- For Members when needed as a result of rapid growth, or
- For Members of any age, when an appliance is damaged and cannot be repaired.

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:

1) Artificial limbs and accessories.
2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes.
3) Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act.
4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
5) Restoration prosthesis (composite facial prosthesis).
6) Wigs needed after cancer treatment.
7) Cochlear implants.

Hearing Aids and Related Services

Benefits include Medically Necessary hearing aids, including bone-anchored hearing aids, as well as FDA-approved over-the-counter hearing aids when Members have been certified as deaf or hearing impaired by a Physician or licensed audiologist, and been given a written prescription. Benefits also include Medically Necessary services to assess, select, adjust or fit the hearing aid. You can get Covered Services from a licensed audiologist or a licensed hearing instrument specialist.

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.

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 Medical Condition)

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

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" 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 areas 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, on behalf of the University, will review your care to decide if a Hospital stay is needed and how many days you should stay. See "Getting Approval for Benefits" for more details.

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

Gender Affirming Services

This Plan provides benefits for gender affirming services, including gender affirming surgery and hormone treatments, for Members diagnosed with Gender Identity Disorder (also known as Gender Dysphoria). To be eligible for benefits, services must be Medically Necessary and all inpatient Facility admissions must

be approved in advance through Precertification. Please refer to the "Getting Approval for Benefits" section for further details.

Gene Therapy Services

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

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

i. Services determined to be Experimental / Investigational;

ii. Services provided by a non-approved Provider or at a non-approved Facility; or

iii. Services not approved in advance through Precertification.

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, an advanced practice registered nurse, or a physician's assistant, and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by the Plan, 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 the Plan.
- 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 may also be available for Inpatient Services in your home. These benefits are separate from 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, 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 chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

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

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

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

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

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

Covered Transplant Procedure

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

Centers of Excellence (COE) Transplant Providers

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

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

In-Network Transplant Provider

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

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

Out-of-Network Transplant Provider

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

Transplant Benefit Period

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

In-Network Transplant Provider agreement. Call the Case Manager for specific In-Network Transplant Provider details for services received at or coordinated by an In-Network Transplant Provider Facility.

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

Prior Approval and Precertification

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

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

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

Transportation and Lodging

The Plan will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. The Plan's 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 the Plan when claims are filed. Call us for complete information.

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

Non-Covered Services for transportation and lodging include:

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

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

Infertility Services

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

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting*****.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Plan. 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. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.
- Newborn diet. Covered Services include a 100% human diet to supplement the mother's expressed breast milk or donor milk with a milk fortifier if the diet is:

  1. Prescribed for the prevention of Necrotizing Enterocolitis and associated comorbidities; and
  2. Administered under the direction of a Physician.

  "100% human diet**"** means supplementing the mother's expressed breast milk or donor milk with a milk fortifier. **"**Milk fortifier**"** means a commercially prepared human milk fortifier made from concentrated 100% human milk.

*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 nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal, and postpartum services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by the 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, the Plan may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, 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.

Endometriosis and Endometritis

Your Plan also covers the diagnosis and treatment of endometriosis and endometritis.

Contraceptive Benefits

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

Sterilization Services

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

Abortion Services

Benefits are limited to abortions performed to preserve the life of the female upon whom the abortion is performed. Elective abortions are not a Covered Service.

Infertility Services

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

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

Mental Health and Substance Use Disorder Services

Covered Services 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.

- **Virtual Visits** as described under the "Virtual Visits (and Telehealth Services)" section.

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

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),

- Licensed professional counselor (L.P.C) 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 (and Telehealth Services)” 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 the Plan.

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.

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. 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 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, subject to age limits defined by the Food and Drug Administration (FDA)

   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 (subject to age limits defined by FDA guidelines).

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, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

Covered Services also include these services as required by state law:

- Routine bone density testing for women.
- Routine colorectal cancer exams and related lab tests as specified in the most recent version of the American Cancer Society guidelines.
- Breast examination including, but not limited to, screening mammograms, diagnostic mammography, breast magnetic resonance imaging (MRI), or breast ultrasound.
- Annual pap smears for women.
- Genetic tests for cancer risk if recommended by the most recent guidelines published by the national Comprehensive Cancer Network (NCCN).

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.

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

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Smoking Cessation

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

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

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

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

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.
- Removal of impacted wisdom teeth.

This Plan does not cover extraction of teeth, surgery for impacted teeth, and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth.

Your Plan does cover certain oral surgeries for children. Please refer to "Dental Services For Members Through Age 20" for details.

Reconstructive Surgery

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

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

Mastectomy Notice

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

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

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

Telemedicine

Covered Services that are appropriately provided by a Telemedicine Provider will be eligible for benefits under this Plan. Telemedicine means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telemedicine does not include the use of facsimile, audio-only telephone, texting or electronic mail. If you have any questions about this coverage, or receive a bill please contact Member Services at the number on the back of your Identification Card.

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.
- **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” 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.

Vision Services For Members Through Age 20

These vision care services are covered for Members through the end of the month in which they turn 21. To receive the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding one, try “Find a Doctor” on our website or call the number on your ID card. See the Schedule of Benefits for 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 including the structure of the eyes and how well they work together.

Eyeglass Lenses

This Plan also covers a choice of eyeglass lenses. Benefits include factory scratch coating.

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 can get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But you can only get one of those three options in a given Benefit Period. (However, one set of replacement lenses may also be covered if Medically Necessary.) 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. Benefits also include a contact lens fitting and evaluation.

- Elective Contact Lenses – These are contacts you chose for comfort or appearance.

- Non-Elective Contact Lenses – These are contacts 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: The Plan 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.

This Plan only covers a choice of contact lenses or eyeglass lenses, but not both. If you choose contact lenses during a Benefit Period, no benefits will be available for eyeglass lenses until the next Benefit Period. If you choose eyeglass lenses during a Benefit Period, no benefits will be available for contact lenses until the next Benefit Period.

Vision Services for Members Age 21 and Older

The vision benefits described in this section only apply to Members age 21 or older. To get the In-Network benefit, you must use a Blue View Vision Provider. If you need help finding a Blue View Vision Provider, please visit our website or call us at the number on the back of your ID card. See the Schedule of Benefits for 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 See the Schedule of Benefits to see your Deductible, Coinsurance, Copayment and other benefit limitations.

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. However, one pair of glasses or contact lenses is covered after surgical removal of the lens(es) of the eyes under the “Prosthetics” benefit.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs, that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting. Benefits for those Drugs are described in the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

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

Important Details About Prescription Drug Coverage

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

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

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including REMS certification (Risk, Evaluation and Mitigation Strategies),
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness,
- 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.

  If you or your doctor believes the step therapy protocol should be overridden in favor of immediate coverage of the doctor's selected Prescription Drug, please have your doctor get in touch with us to request a step therapy exception.

  We will respond to requests for step therapy exceptions within 48 hours of receiving all necessary information to conduct the step therapy review. Our response will indicate whether the exception request is approved, denied, or requires additional information.

  If the step therapy exception request is denied you have the right to file an internal appeal as outlined in the "Complaint and Appeals" section of this Booklet. If we fail to approve, deny or advise you or your prescribing doctor that additional information is needed within 48 hours of receiving an internal appeal of the denial of a step therapy exception, the exception is deemed approved.

  If an internal appeal for a step therapy exception is denied, you have the right to an external review of the denial as outlined in the "If You Have a Complaint or an Appeal" 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 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. The results of the Plan's decision will be given to both you and your Provider.

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

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

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

Designated Pharmacy Provider

Anthem 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. The Plan reserves the 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. The Plan may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in the Plan's 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.

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.

The Plan, on behalf of the University, 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 performed to preserve the life of the female upon whom the abortion is performed.

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 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 trachea-esophageal voice devices approved by Anthem.

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

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

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

7) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include masseurs or masseuses (massage therapists), physical therapist technicians, and athletic trainers, Telehealth providers not licensed in Kentucky and not participating in an interstate medical compact.

8) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Servicesexcept for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet.

9) **Charges Not Supported by Medical Records** Charges for services not described in your medical records, except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the front of this Booklet.

10) **Chats or Texts** Chats and texting are not a Covered Service unless appropriately provided via a secure and compliant application, according to applicable legal requirements.

11) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

12) **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

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

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

14) **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

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

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

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

17) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if 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. This Exclusion also does not apply unless the Member is incarcerated in a local penal institution or in the custody of a local law enforcement officer as a result of a conviction for a felony.

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

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

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

21) **Dental Devices for Snoring** Oral appliances for snoring.

22) **Dental Services:**

a) Dental care for Members age 21 or older except for those services covered under the "Dental Services (All Members / All Ages)" benefit or those services covered under the "Oral Surgery section of the "Surgery" benefit.

b) Oral hygiene instructions.

c) Case presentations.

d) Enamel microabrasion and odontoplasty.

e) Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes tooth whitening agents or tooth bonding and veneer covering of the teeth.

f) Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.

g) Pulp vitality tests.

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

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

j) Incomplete root canals.

k) Bacteriologic tests for determination of periodontal disease or pathologic agents.

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

m) Services of anesthesiologists, except for those services covered under the "Dental Services (All Members / All Ages)" benefit or services covered under the "Oral Surgery" section of the "Surgery" benefit.

n) Anesthesia Services (such as intravenous or non-intravenous conscious sedation and general anesthesia) are not covered when given separate from complex surgical services.

o) Additional, elective or enhanced prosthodontic procedures including connector bar(s), stress breakers and precision attachments.

p) Separate services billed when they are an inherent component of another Covered Service.

q) Cone beam images.

r) Sinus augmentation.

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, based upon FDA labeling.

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/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by Anthem.

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 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 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. Please see "Additional Information about Experimental / Investigational Services" at the end of this section for more details.

31) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight except as 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 Members through age 20.

33) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes 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) **Flight** in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.

36) **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:

    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.

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

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

39) **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.

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

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

    This Exclusion does not apply to a Member incarcerated in a local penal institution or in the custody of a local law enforcement officer prior to conviction for a felony.

41) **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.

42) **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.

43) **Home Health Care**

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

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

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

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

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

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

48) **Maintenance Therapy** 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 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 "Medicare" section in “General Provisions.”

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

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

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

54) **Non-Medically Necessary Services** Services we, on behalf of the University, conclude are not Medically Necessary. This includes services that do not meet the Plan’s medical policy, clinical coverage, or benefit policy guidelines.

55) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements. This Exclusion includes 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 therapeutic food, formulas, supplements, and low-protein modified food products covered under the “cription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” benefit or to the newborn diet covered under the “Inpatient Services” benefit.

56) **Off label use** Off label use unless the Plan approves it.

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

58) **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.

59) **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.

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

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

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.

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

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

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

65) **Services Received Outside the United States** Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance.

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

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

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

69) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple).

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

71) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs. This Exclusion does not apply to the travel and lodging services covered under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services" benefit.

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

73) **Vision Services**

a) Vision services for Members age 21 or older, unless listed in this Booklet.

b) Eyeglass lenses, frames, or contact lenses for Members Age 21 and older, unless listed as covered in this Booklet.

c) Safety glasses and accompanying frames.

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

e) Plano lenses (lenses that have no refractive power)

f) Lost or broken lenses or frames if the Member has already received benefits during a Benefit Period. This Exclusion does not apply, however, to one set of replacement lenses or frames if they are Medically Necessary.

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

h) Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, except as listed under “Vision Services for Members Through Age 20” in the Schedule of Benefits.

i) Blended lenses.

j) Oversize lenses.

k) Sunglasses and accompanying frames.

l) 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.

m) For Members through age 20, no benefits are available for frames or contact lenses not on the Anthem formulary.

74) **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

75) **Weight Loss Programs** Weight loss programs, whether or not under medical supervision. This Exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

76) **Weight Loss Surgery** Bariatric surgery. This includes 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.

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

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

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

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

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

Provider Network Status

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

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of 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 the Plan:

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

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the 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 the Plan using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

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

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

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

The 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 Tier 2 In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a non Emergency Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. If we authorize a Tier 2 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 is a Surprise Billing Claim. Please contact Member Services for Authorized Services information or to request authorization.

The Plan provides coverage for Emergency Services without the need for any prior approval for services that meet the definition of Emergency Care, whether the care is rendered by an In-Network Provider or Out-of-Network Provider. The Plan will apply the In-Network cost share amount for Emergency Care rendered by an Out-of-Network Provider, however the Member may be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowable Amount.

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

Example:
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 the Plan 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, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Notice of Claim & Proof of Loss

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

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

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

  - Name of patient.
  - Patient's relationship with the 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, the claims will process according to the terms of your Plan.

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

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

Member's Cooperation

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

Payment of Benefits

You authorize the Plan to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator reserves the right to make payments directly to you as opposed to any Provider for Covered Services, at the Claims Administrator's discretion, except for claims for Emergency Care or Surprise Billing Claims for air ambulance services or non-Emergency services performed by Out-of-Network Providers at certain In-Network Facilities, which will be paid directly to Providers and Facilities. 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 Student who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the University's Plan), or that person's custodial parent or designated representative. Any payments made by the Claims Administrator (whether to any Provider for Covered Service or You) will discharge the

University's obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, any applicable Federal law.

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

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

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

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

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

B. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

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

2. **Exceptions**

In certain situations, 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 the Plan will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core® Program

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

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

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

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

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

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

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

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

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

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

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

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

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

Applicability

This provision applies when you have health or dental care coverage under more than one Plan. For the purposes of this provision, "Plan" is defined below.

If this provision applies, the Order of Benefit Determination Rules specify whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

1. Will not be reduced when, under the Order of Benefit Determination Rules, this Plan determines its benefits before another Plan; but

2. May be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The reduction is described under the heading "Effects on the Benefits of this Plan."

Definitions

Plan - this Plan and any other arrangement providing health or dental care or benefits for health or dental care through:

1. Group insurance or group-type coverage whether insured or uninsured. This shall not include the medical benefits coverage in a group, group-type, and individual motor vehicle “no-fault” and traditional automobile “fault” type contracts. This does include prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

2. Individual insurance for individual-type coverage. This includes prepayment, group practice, or individual practice coverage.

3. Coverage under a governmental Plan or coverage required or provided by law except Medicaid.
4. Any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee Plan, a union welfare Plan, an employee organization Plan or an employee benefit organization.

5. Any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

"Plan" does not include any of the following:

1. Group or group-type fixed indemnity medical expense reimbursement policies.

2. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis.

Primary Plan/Secondary Plan - the Order of Benefit Determination Rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

Primary plan means a plan whose benefits shall be determined without taking the existence of any other plan into consideration if:

1. The plan either has no order of benefits determination requirements, or

2. All plans that cover the person use the order of benefits determination requirements as listed in the Order of Benefit Determination Rules section.

When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

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.

Allowable Expense - a health or dental care service or expense including Deductibles, Coinsurance or Copayment, that is covered in full or in part by any of the plans covering the person.

The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of accepted medical practice or as specifically defined in this Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When the benefits are reduced under a Primary Plan because a Member does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, Precertification of admissions or services, and Preferred Provider arrangements. Only benefit reductions based upon provisions similar to this one and which are contained in the Primary Plan may be excluded from Allowable Expenses. This provision shall not be used by a Secondary Plan to refuse to pay benefits because a health maintenance organization (HMO) member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to its Contract, is not obligated to pay for providing those services.

Allowable Expense does not include the amount that is subject to the Primary high-deductible health plan’s deductible, if we have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986**.**

Order of Benefit Determination Rules

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of this Plan; and

2. Both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. Pediatric Dental Coordination of Benefits (COB). These pediatric dental COB provisions are applicable to only the pediatric dental benefits found in the “Dental Services For Members Through

Age 20" benefit in the "What's Covered" section. If pediatric dental Essential Health Benefits are included as part of the medical plan, the medical plan will be primary coverage and any standalone dental plan will be secondary. If the member has two medical plans, each offering pediatric dental Essential Health Benefit coverage for spouse and family, the Order of Benefits Determinations rules below apply.

2. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee or Student (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.

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:

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

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

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

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

      1. 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;

      2. 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;

      3. 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

      4. 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:

         a. The Plan covering the Custodial parent;

         b. The Plan covering the spouse of the Custodial parent;

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

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

   4. 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.

   5. Joint Custody. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the

child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined in paragraph 2.

6. Active/Inactive Member. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule 5 is ignored. This rule does not supersede rule 1 above.

7. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

    a. First, the benefits of a Plan covering the person as an employee, Student or Member or as that person's Dependent;

    b. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

8. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered the person longer are determined before those of the Plan which covered that person for the shorter term. If none of the preceding rules determines the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on this Plan's Benefits

When a Member is covered under two or more Plans which together pay more than the Allowable Expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan’s benefit payments will not be affected when it is Primary. However, when this Plan is Secondary under the Order of Benefit Determination Rules, benefits payable will be reduced, if necessary, so that combined benefits of all Plans covering you or your Dependent do not exceed the Allowable Expense.

When this Plan is Secondary, you will receive credit during the calendar year for the amount by which your benefits are reduced. This credit will not be applied to the extent that would cause you to receive:

1. A combined benefit from all Plans greater than the Allowable Expense; or

2. More benefits during a calendar year than you would receive if there were no other coverage.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. The Plan 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 needed to pay the claim.

Facility of Payment

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

Right of Recovery

If the amount of the payment made by the Plan is more than it should have paid under this provision, we may recover the excess from one or more of:

1. The persons we have paid or for whom we paid;

2. Insurance companies; or

3. Other organizations.

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

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery. A Recovery 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

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

- The Plan have first priority for the full amount of benefits it has 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 the Plan to exercise the Plan's rights and do nothing to prejudice them.
- The Plan has the right to take whatever legal action it sees 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 the Plan's subrogation claim and any claim still held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, other expenses or costs you incur 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 the Plan to the extent of benefits it has paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Plan shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery.
- Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

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

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

Your Duties

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

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

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

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

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

Your Right to Appeal

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

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

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card. Our Member Services representatives are specially trained to answer your questions about our health plans. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Deductible, Coinsurance, or Copayment amounts;
- Specific claims or services you have received;
- Doctors or Hospitals in the network;
- Authorizations; and/or
- Provider directories.

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the appeals process. A complaint process also exists to help you understand the Plan's determinations.

The Complaint Process

A complaint procedure is available to provide reasonable, informative responses to complaints that you may have about us. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from us of our procedures and contracts. We invite you to share any concerns that you may have over benefit determinations, coverage cancellations, or the quality of care rendered by Providers in our networks.

If you have a complaint or problem concerning benefits or services, please contact us. Please refer to your Identification Card for our address and telephone number. You may send in your complaint by letter or by phone call. Or, if you wish, you may meet with your local service representative to discuss your complaint. Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within six months after receipt of notice of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

The Appeals Process

An appeal is a formal request from you that asks us to change a previous determination. If you are notified in writing of any Adverse Determination or Coverage Denial, you will be advised of your right to an internal appeal and an external review if appropriate. You also have a right to appeal if we fail to make a Utilization Review determination and provide written notice within the required time frame if our failure to make a determination or provide notice of a determination within the required time frame is as a result of circumstances beyond our control. For purposes of this section:

- Coverage Denial means our determination that a service, treatment, Drug or device is specifically limited or excluded under this Booklet.

- Adverse Determination means our denial, reduction, or termination of a benefit (either in whole or in part) based on any of the following:

- A determination that you are not eligible to participate in the Plan, including the denial, reduction, or termination of a benefit (in whole or in part) as a result of a utilization review;
- A determination that the benefit is Experimental / Investigational or not Medically Necessary;
- A determination that the benefit is not a covered benefit under the Plan; or
- A determination that the benefit is excluded due to a limitation in the Plan.

Adverse Determination includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit.

The internal appeals process may be initiated by you, your authorized representative, or a Provider acting on your behalf within 60 days of the date you get our written notice of an Adverse Determination, a Coverage Denial or any other adverse decision we made, but must be filed within six months of the date you get the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by you relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the appeal.

In addition, we will also provide you, free of charge, with any new or additional evidence we will consider, rely upon, or generate in connection with the claim, as well as our rationale for making any Adverse Determination. We will provide this as soon as possible and sufficiently in advance of the date on which the final Adverse Determination is due, by law, to give you a reasonable opportunity to respond prior to that date.

You will continue to get coverage under the Plan pending the outcome of the internal appeal, as long as you remain eligible for coverage. If you have undertaken an ongoing course of treatment, we will only reduce or terminate it after giving you advance notice.

If a representative is seeking an appeal on your behalf, we must get a signed Designation of Representation (DOR) form from you. The appeal process will not begin until we get the properly completed DOR form. The only exception to this is if a Physician requests an expedited internal appeal on your behalf, the Physician will be deemed to be your representative for the purpose of filing the expedited internal appeal even though we did not get the signed form. We will forward a Designation of Representation form to you to complete in all other situations.

We will ensure that appeals are reviewed in a manner designed to ensure the independence and partiality of the individuals responsible for reviewing your request (referred to as qualified reviewers). The qualified reviewers will not be the same people who made the initial denial or determination. They will not be the subordinates of the initial decision maker either and no deference will be given to the initial decision. If the internal appeal is related to an Adverse Determination or any other adverse decision that is based in whole or in part on a medical judgment, at least one person conducting the appeal will be a licensed Physician (or if the determination involves services rendered by a Chiropractor or Optometrist, a Chiropractor or Optometrist licensed in Kentucky) unless a nurse can approve the request. If the appeal is related to a medical or surgical specialty or subspecialty, upon your request of the request of your authorized representative or Provider, at least one person conducting the appeal will be a board eligible or certified Physician in the appropriate specialty or subspecialty.

Within a reasonable time given the medical circumstances and no later than 30 days after we get a written or an oral request for appeal, we will send a written decision to you or your authorized representative and, if applicable, your Provider.

If we fail to resolve the appeal with the required time, you may pursue external review as described later in this section. This option is not available, however, if our failure to resolve the appeal is due to a de minimus violation that does not cause harm to you or is not likely to cause prejudice or harm to you, if the delay is for good cause or due to matters beyond our control, and is part of an ongoing, good faith exchange of information between you and us.

Expedited Appeals

An expedited appeal is deemed necessary when you are hospitalized, or in the opinion of the treating Provider (or any Physician with knowledge of your medical condition), review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing the your health or, with respect to a pregnant woman, your health or your unborn child's health in serious jeopardy;
- Subjecting you to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions;
- Serious dysfunction of a bodily organ or part; or
- Any claim that a Physician with knowledge of your medical condition determines is a claim involving urgent care.

In addition, Members in urgent care situations and Members receiving an ongoing course of treatment may be allowed to proceed with an expedited external review at the same time as the internal appeals process.

The Plan, applying a prudent lay person standard, may also determine that an appeal may be expedited. The request for an expedited internal appeal may be in writing or an oral request, followed up by an abbreviated written request by you, your authorized representative or Provider acting on your behalf. We have the right to require verification from the treating Provider (or other Physician with knowledge of your medical condition), that your condition warrants an expedited internal appeal.

The process for the expedited internal appeal is similar to the standard internal appeal, except that we will communicate our decision to you or your authorized representative as soon as possible taking into account the medical urgency of the situation, but no later than 72 hours after receipt of the request for an expedited internal appeal. All necessary information, including our decision on review, shall be transmitted between us and you or your authorized representative by phone, facsimile, or other available similarly expeditious method.

If our decision is to uphold a Coverage Denial, you, your authorized representative or a Provider acting on behalf of and with your consent may contact the Kentucky Department of Insurance, Health and Life Division, 500 Mero Street, P.O. Box 517, Frankfort, KY 40602, and request a review of our decision. The Department will make a determination as to whether the service should or should not be covered. If the Department determines the disputed service should be covered, it may direct us to either pay the service or offer external review to resolve the issue.

External Review by an Independent Review Entity

You, your authorized representative, or a Provider acting on your behalf and with your consent may request an external review of an Adverse Determination if the following criteria are met:

- The internal appeal process outlined above was completed or jointly waived by you and us or we failed to make a decision within 30 days of receiving the written appeal or within 72 hours of receiving the request for an expedited appeal; and

- You were covered under this Plan on the date of service or, if a prospective denial, you were eligible to receive benefits under this Plan on the date the proposed service was requested.

The request for an external review of an Adverse Determination must be sent to us within 4 months of the date you get our written decision rendered under the internal appeals process. As part of the request, you shall provide written consent authorizing the independent review entity to get all medical records from us and any Provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

We will determine if your request qualifies for independent review and will refer all eligible requests to the Kentucky Department of Insurance, who will assign an independent review entity. Independent review entities are assigned on a rotating basis so that we do not have the same independent review entity for two consecutive external reviews. We will inform you in writing of the independent review entity that will conduct the review and inform you of your right to submit additional information to the independent review entity within 5 days. If the independent review entity receives the information within 5 days they will include it in their review and forward a copy to us within one day. We will also forward all information required to be considered for an external review to the independent review entity within three business days of assignment.

You will be assessed a filing fee of $25 to be paid to the independent review entity. This fee may be waived if the independent review entity determines that the fee creates a financial hardship on you. The fee shall be refunded if the independent review entity finds in your favor. If you send in multiple requests for external review within a one-year period, you will not have to pay more than $75 per year in filing fees. We will pay the rest of the cost of the external review.

The independent review entity will send a written decision to you within 21 days from the date they get of all information required from us. An extension of up to 14 days may be allowed if agreed to by you and us. In no event will the independent review entity take longer than 45 days to complete their review.

You will not be able to get an external review of an Adverse Determination if:

- Your Adverse Determination has previously gone through the external review process and the independent review entity found in our favor; and

- No new relevant clinical information has been sent to us since the independent review entity found in our favor.

If a dispute arises between us and you about the right to an external review, you may file a complaint with the Kentucky Department of Insurance. Within five days of the date they get your complaint, the Department will make a decision. They may direct us to send the dispute to an independent review entity for an external review if they find that the dispute involves denial of coverage based on Medical Necessity or the service being Experimental / Investigational and all other external review requirements have been met.

Expedited External Reviews

External reviews shall be done in an expedited manner by the independent review entity if you are hospitalized, or if, in the opinion of the treating Provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

- Placing your health or, with respect to a pregnant woman, your health or your unborn child’s health in serious jeopardy;
- Subjecting you to severe pain that cannot be adequately managed;
- Serious impairment to bodily functions; or
- Serious dysfunction of a bodily organ or part.

Expedited reviews are also available if you are requesting review of a decision that a recommended or requested service is Experimental / Investigational and your Physician certifies in writing that the requested service would be significantly less effective if not promptly initiated.

You may pursue an expedited external review while simultaneously pursuing an expedited internal appeal.

The request for an expedited external review may be in writing or an oral request, followed up by an abbreviated written request, by you, your authorized representative or a Provider acting on your behalf and with your consent. Requests for expedited external review shall be sent by us to the independent review entity within 24 hours of receipt. We will call the independent review entity to confirm that a specialist is available and that the review has been accepted.

For expedited external review, a decision shall be made by the independent review entity within 24 hours of getting all information required from us. An extension of up to 24 hours may be allowed if agreed to by you and us. We will provide notice to the independent review entity and to you the same day that the Adverse Determination has been assigned to an independent review entity for expedited review. In no event will the independent review entity take longer than 72 hours to complete their review.

The Decision of the Independent Review Entity

The independent review entity shall provide you, your treating Provider, the Kentucky Department of Insurance and us a decision which shall include:

- The findings for either us or you regarding each issue under review;
- A summary of the proposed service, treatment, drug, device or supply for which the review was performed;
- The relevant provisions in the Plan and how they were applied; and
- The relevant provisions of any nationally recognized and peer-reviewed medical or scientific documents used in the external review.

Records provided to independent review organizations are handled as confidential records.

The decision of the independent review entity will be binding on us and you except to the extent that there are remedies available under applicable state or federal law.

Who to Contact for Appeals and External Review

The request for an internal appeal or an external review and supporting documentation must be sent to the address or phone number below or to the appeal address or phone number provided on your written notice of an adverse decision:

Position: Appeals Coordinator

For medical, Prescription Drug or Pharmacy issues:

Mailing address: P.O. Box 105568, Atlanta, GA 30348-5568
Phone number: Please see the number on the back of your ID card.

For “Dental Services for Members Through Age 20” issues:

Mailing address: P.O. Box 1122 Minneapolis, MN 55440-1122
Phone number: Please see the number on the back of your ID card.

For "Vision Services for Members Through Age 20" or "Vision Services for Members Age 21 and Older" issues:

Mailing address: Blue View Vision, P.O. Box 9304, Minneapolis, MN 55440-9304
Phone number: Please see the number on the back of your ID card.

The person holding the position named above will process your request.

We encourage you to submit any requests for appeals or external review in writing. The request should describe the problem in detail. Please attach copies of bills, medical records, or other appropriate documents to support your position.

You must file appeals on a timely basis. You are encouraged to file internal appeals within 60 days of the date you get our initial decision, and must file internal appeals within six months of the date you get our initial decision. If the right to external review exists as described above, you must file the external review request within 4 months of the date you received our final decision on your internal appeal.

Medical Services

We are not liable for Covered Services that you do or do not get from a Provider. You shall have no claim against us for acts or omissions of any Provider from whom you receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within three years of our final decision on the claim or other request for benefits. If we decide an appeal is untimely, our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust our internal appeals process before filing a lawsuit or other legal action of any kind against us.

Eligibility and Enrollment – Adding Members

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

Who is Eligible for Coverage

The Student

Qualifying fully funded graduate students that are enrolled in a course through the Graduate School, degree seeking, and maintains a full-time qualifying paid assistantship or fellowship through UK payroll, are automatically enrolled in the Plan upon eligibility confirmation.

Coverage can be purchased on an optional basis by any undergraduate or BCTC student that is enrolled in at least 6 credit hours and all other students, including health sciences, law, non-funded graduates, and professional students enrolled in at least 2 credit hours.

All J1, J2 or F1 visa students who are registered for any course are eligible to be enrolled in the Plan at registration and the premium for coverage is added to their tuition billing. Enrollment in the Plan is required unless proof of comparable coverage is furnished.

Dependents

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

- The Student's spouse. For information on spousal eligibility please contact the University.

- The Student's spouse unless spouses are not eligible under the University's Plan. For information on spousal eligibility please contact the University. If spouses are not eligible under this Plan, any references to spouses in the "Eligibility and Enrollment – Adding Members" and "Termination of Coverage" sections of this Booklet do not apply.

- The Student's Domestic Partner, if Domestic Partner coverage is allowed under the University's Plan. Please contact the University to determine if Domestic Partners are eligible under this Plan. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex who has signed the Domestic Partner Affidavit certifying that he or she is the Student's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Student by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Student.

  For purposes of this Plan, a Domestic Partner shall be treated the same as a spouse, and a Domestic Partner's child, adopted child, or child for whom a Domestic Partner has legal guardianship shall be treated the same as any other child.

  Any federal or state law that applies to a Member who is a spouse or child under this Plan shall also apply to a Domestic Partner or a Domestic Partner's child who is a Member under this Plan. This includes but is not limited to, COBRA, FMLA, and COB. A Domestic Partner's or a Domestic Partner's child's coverage ends on the date of dissolution of the Domestic Partnership.

  To apply for coverage as Domestic Partners, both the Student and the Domestic Partner must complete and sign the Affidavit of Domestic Partnership in addition to the Enrollment Application, and must meet all criteria stated in the Affidavit. Signatures must be witnessed and notarized by a notary

public. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

- The Student's or the Student's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the University has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.

- Children for whom the Student or the Student's spouse is a legal guardian or as otherwise required by law.

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits. Coverage may be continued past the age limit in the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to a mental or physical impairment. The Dependent's impairment must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You must then give proof as often as we require. This will not be more often than once a year after the two-year period following the child reaching the limiting age. You must give the proof at no cost to the Plan. You must notify us if the Dependent's marital status changes and they are no longer eligible for continued coverage.

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

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

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 Domestic Partner;
- Student and one child**;**
- Student and child(ren);
- Student and family.

When You Can Enroll

Enrollment

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

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth of a child, you should submit an application / change form to the University within 31 days to add the newborn to your Plan.

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

If additional Fees are required, your newborn's coverage will only continue past the initial 31 days if you send the application / change form and pay the additional Fees within 31 days of the birth to the Plan.

Adopted Children

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

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

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.

The Plan will cover your child under this Plan once we get the application from you, the child's other parent, and the Cabinet for Health and Family Services.

After the child is covered, and as long as you are eligible under this Plan, the Plan will continue to cover the child unless we get satisfactory written evidence that the court order is no longer in effect or that the child has coverage under another health plan that provides comparable health coverage.

A child's coverage will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Updating Coverage and/or Removing Dependents

You are required to notify the 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 family member (a different type of coverage may be necessary);
- Enrollment in another health plan or in Medicare;
- Eligibility for Medicare;
- Dependent child reaching the Dependent Age Limit (see "Termination of Coverage");
- Enrolled Dependent child either becomes totally or permanently disabled, or is no longer disabled.

Failure to notify the Plan of individuals no longer eligible for services will not obligate the Plan to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms. The Plan will return any unearned fees as required by Kentucky law.

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 Plan 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 and/or the University may reasonably request.

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

Termination of Coverage

Termination

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

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

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

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

Conversion

Any Member (e.g., the Student or his / her Dependents) that is covered under this Plan, or any Group plan it replaced, for at least 3 months may buy a conversion health plan when coverage under this Plan ends. The conversion health plan will have benefits similar this Plan.

The Plan will send the offer of the conversion plan to the Student at their last known address. To buy the coverage, the Plan must get the Fees and written application for the conversion plan no later than:

- 31 days after coverage ends if the Student is given written notice of conversion option when their coverage ends; or

- 60 days after the Student is given written notice of the conversion plan option, if the Plan failed to send the offer when their coverage originally ended.

Please note that conversion coverage is not available to Members eligible for, or covered by, Medicare or another group plan, or for Members covered by substantially similar benefits by another individual hospital, surgical, or medical expenses insurance policy. It also is not available if issuing the conversion contract will make the Member over insured according to the Plan's rules.

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

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

Circumstances Beyond the Control of the Plan

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

Clerical Error

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

Confidentiality and Release of Information

Applicable state and federal law requires the Plan 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 federal law and any applicable state 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 Health Plans of Kentucky, 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 Kentucky. 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 Health Plans of Kentucky, Inc. and that no person, entity, or organization other than Anthem shall be held accountable or liable to the University for any of Anthem‘s obligations to the University created under the Administrative Services Agreement. 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

This Booklet, the Administrative Services Agreement, 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 the Plan and as of the Effective Date, supersede all other agreements. Any and all statements made to the Plan by the University and any and all statements made to the University by the Plan 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 the University.

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 the Plan 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 the Plan.

Medical Policy and Technology Assessment

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

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

Medicare

Any person who has Medicare at the time of enrollment in this student insurance plan is not eligible for coverage under the Master Policy. If an Insured Person obtains Medicare after the Insured Person is covered under the Master Policy, the Insured Person's coverage, for the active coverage period, will not end due to obtaining Medicare. The Insured Person will not be eligible for coverage under the Master Policy for any following coverage periods. As used here, "has Medicare" means that an individual is entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A. Non-Dependent/Dependent: The benefits of the Plan which covers the person a member or subscriber are determined before those of the Plan which covers the person as a Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVII of the Social Security Act and implementing regulations, Medicare is both (i) secondary to the Plan covering the person as a dependent; and (ii) primary to the person as a member, subscriber, policyholder, or retiree is the Secondary Plan and the other Plan covering the person as a dependent is the Primary Plan.

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

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the University, or by mutual agreement between the Claims Administrator and the University without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof. Not Liable for Provider Acts or Omissions. The Plan is not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem or the Plan based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

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

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total

compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

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

Policies, Procedures, and Pilot Programs

We, on behalf of the University, 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 Administrative Service Agreement with your University, we have the authority, in our 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 agreed to by the University. We reserve the right to discontinue a pilot or test program at any time without advance notice to the University.

Program Incentives

We, on behalf of the University, 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 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 a fiduciary agent of the Member. Our notice to the University will constitute effective notice to the Member. 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 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, the Plan will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered. Except in cases of fraud, we will only recover such payment from the Provider during the 24 months after the date we made the payment on a claim submitted by the Provider.

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

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.

University's Sole Discretion

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

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 student health Plan and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

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

Voluntary Clinical Quality Programs

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

Administrative Services Agreement

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

Ambulatory Surgery Center

A Facility licensed as an Ambulatory Surgery Center as required by law that must satisfy our accreditation requirements and, for an In-Network Provider, be approved by us.

Authorized Service(s)

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

Benefit Period

The length of time the Plan will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your 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 the Plan 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:

1) Known gene-drug interaction for medications being considered for use or already being administered; and
2) 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 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, which describes the terms of your benefits while you are enrolled in the Plan.

Brand Name Drugs

Prescription Drugs that we classify as Brand Drugs or that the Plan's 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.

Claims Administrator

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

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" at the front of this Booklet for details.

Controlled Substances

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

Copayment

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

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date of you enter the Facility. Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

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

Custodial Care

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

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

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

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

Deductible

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

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

Please see the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "What's Covered" section.

Emergency Care

Please see the "What's Covered" section.

Enrollment Date

The first day you are covered under the Plan or, if the University imposes a waiting period, the first day of your waiting period. Should the University choose to impose a waiting period, it will not exceed 90 days.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

Please see the "What's Not Covered" section.

Facility

A facility including, but not limited, a Hospital, freestanding Ambulatory Surgery Center, Residential Treatment Center, Skilled Nursing Facility, as defined in this Booklet. The Facility must be licensed as required by law, satisfy the Plan's accreditation requirements, and for an In-Network Provider, be approved by us.

Fee(s)

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

Generic Drugs

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

Home Health Care Agency

A Provider licensed when required by law and, for an In-Network Provider, approved by the Plan, 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 the Plan's accreditation requirements and, for an In-Network Provider, be approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care

Identification Card (ID Card)

The card given to you 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. The name of network for this Plan is listed on your ID card.

In-Network Transplant Provider

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

Inpatient

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

Intensive Outpatient Program

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

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has

been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

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 the Plan 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 that is determined by the Plan 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);
- Not Experimental / Investigational;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an Exclusion under this Plan.

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 have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Mental Health and Substance Use Disorder

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

Non-Participating Dentist

A dentist who has NOT signed a written provider service agreement agreeing to service the program identified in this Certificate. Anthem will reimburse Non-Participating Dentists according to the Maximum Allowed Amount for Non-Participating Dentists. The Maximum Allowed Amount reimbursement may be different for Participating Dentists.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility and Enrollment – Adding Members" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

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

Out-of-Network Transplant Provider

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

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your 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.

Participating Dentist

A dentist who has signed a written provider service agreement agreeing to service the program identified in this Certificate. The dentist has agreed to accept Anthem’s Maximum Allowed Amount as payment full for dental care covered under this plan.

Pharmacy

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

Pharmacy and Therapeutics (P&T) Process

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

Pharmacy Benefits Manager (PBM)

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

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

Physician (Doctor)

Includes the following when licensed by law:

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

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

Plan

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

Plan Administrator

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

Plan Sponsor

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

Precertification

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

Prescription Drug (Drug)

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

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

Prescription Order

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

Primary Care Physician ("PCP")

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, geriatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Primary Care Provider

A Physician, nurse practitioner, clinical nurse specialist, Physician assistant, 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 the Plan's accreditation requirements and, for In-Network Providers, be approved by the Plan. Details on the accreditation requirements can be found at https://www.anthem.com/provider/credentialing/. This includes any Provider that state law says must be covered when they give you Covered Services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Qualifying Payment Amount

The median Plan In-Network contract rate the Plan pays 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 the Plan's 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 the Plan’s accreditation requirements, and be approved by the Plan.

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

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “ Eligibility and Enrollment – Adding Members” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Student

A student who is eligible for and has enrolled in the Plan according to the rules stated under the “Eligibility and Enrollment – Adding Members” section.

Surprise Billing Claim

Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the front of this Booklet for details.

Total Disability (or Totally Disabled)

A condition where you are not able to perform any occupation or business for which you are reasonably suited by your education, training, or experience. This also means that you are not, in fact, engaged in any occupation or business for wage or profit. It includes conditions where you are confined to a Hospital or are completely incapacitated and unable to perform normal activities of daily living. We may require your Physician to send us proof of your condition.

Transplant Benefit Period

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

University or School

A educational institution who has allowed its Students to participate in the Plan by acting as the Plan Sponsor. The educational institution has an Administrative Services Agreement with the Claims Administrator to administer 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.