BENEFIT BOOKLET

FOR

STATE OF OHIO – OHIO MED PPO PLAN

ADMINISTERED BY

EFFECTIVE 07/01/2020

PACKAGE CODE 001

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the health care plan (the "Plan") offered by the State of Ohio. You should read this booklet carefully to familiarize Yourself with the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact the State or call the Anthem's Member Services Department at 1.844.891.8359.

The Plan provides the benefits described in this Benefit Booklet only for eligible Members. The health care services are subject to the Limitations and Exclusions, Copayments, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Benefit Booklet.

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

Anthem Blue Cross Blue Shield has been designated by the State of Ohio to provide administrative services for the Ohio Med Plan, such as claims processing, care management, and other services, and to arrange for a Network of health care Providers whose services are covered by the Plan.

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

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

Verification of Benefits

Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Member Services with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 7:00 p.m. Eastern Time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. CALL 1.844.891.8359 or see the section titled **Health Care Management for Precertification** rules.

Identity Protection Services

Identity protection services are available with Your Employer's Anthem health plans. To learn more about these services, please visit www.anthem.com/resources.

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MEMBER RIGHTS AND RESPONSIBILITIES

As a Member You have rights and responsibilities when receiving health care. As Your health care partner, Anthem wants to make sure Your rights are respected while providing Your health benefits. That means giving You access to Anthem's network health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

You have the right to:

- Speak freely and privately with Your health care Providers about all health care options and treatment needed for Your condition no matter what the cost or whether it is covered under Your Plan.
- Work with Your Doctors to make choices about Your health care.
- Be treated with respect and dignity.
- Expect Anthem to keep Your personal health information private by following Anthem's privacy policies, and state and Federal laws.
- Get the information You need to help make sure You get the most from Your health Plan, and share Your feedback. This includes information on:
  - Anthem's company and services.
  - Anthem network of health care Providers.
  - Your rights and responsibilities.
  - The rules of Your health Plan.
  - The way Your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care You receive.
  - Any Covered Service or benefit decision that Your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care You may get in the future. This includes asking Your Doctor to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of Your illness, Your treatment and what may result from it. You can ask for help if You do not understand this information.

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health Plan rules and policies.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give Anthem, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with the Plan.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

If You would like more information, have comments, or would like to contact Anthem, please go to anthem.com and select Customer Support > Contact Us. Or call 1.844.891.8359.

Anthem wants to provide high quality Customer Service to our Members. Benefits and coverage for services given under the Plan are governed by the State's Plan and not by this Member Rights and Responsibilities statement.

How to Obtain Language Assistance
Anthem is committed to communicating with our members about their health plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our Member Services Call Centers. Simply call the Member Services phone number at 1.844.891.8359 and a representative will be able to assist You. Translation of written materials about Your benefits can also be requested by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with Your needs.

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 1.844.891.8359.

SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount Anthem will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan; are Medically Necessary; and are provided in accordance with the Member's Plan. See the Definitions and Claims Payment section

s for more information. Under certain circumstances, if Anthem pays the healthcare Provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, Anthem may collect such amounts directly from You. You agree that Anthem has the right to collect such amounts from You.

SCHEDULE OF BENEFITS	NETWORK	OUT-OF-NETWORK
Plan Year Deductible • Individual • Family **Your Plan has an Embedded Deductible which means:** • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If You also cover Dependents (other family members) under this Plan, both the "Individual" and the "Family" amounts apply. The "Family" Deductible amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Deductible amount before the "Family" amount is met. You will never have to satisfy more than Your own 'Individual" Deductible amount. If You meet Your "Individual" Deductible amount, Your other family member's claims will still accumulate towards their own "Individual" Deductible and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Deductible or the entire "Family" Deductible is met. Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.	 $400 $800	 $800 $1,600
Amounts satisfied toward the Network Plan year Deductible will be applied toward the Out-of-Network Plan year Deductible and amounts satisfied toward the Out-of-Network Plan year Deductible will be applied toward the Network Plan year Deductible.		
Coinsurance After the Plan Year Deductible is Met (Unless Otherwise Specified) • Plan Pays • Member Pays All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.	 80% 20%	 60% 40%

SCHEDULE OF BENEFITS	NETWORK	OUT-OF-NETWORK
Copayment Amounts		
• Office / Outpatient Visits – Non-Specialist Provider	$30	$50
• Office / Outpatient Visits – Specialist Provider	$35	$55
• Emergency Room for Emergency Medical Conditions	$150	$150
• Emergency Room for Non-Emergency Medical Conditions	$150	$150
• Retail Health Services (For example, Minute Clinics)	$20	$30
• TeleHealth Visit	$10	N/A
• Urgent Care	$40	$50
Out-of-Pocket / Coinsurance Maximum (Includes Coinsurance, Copayments and the Plan Deductible.) Does NOT include Non-Covered Services, Services deemed not Medically Necessary by Medical Management and/or Anthem, Penalties for Non-Compliance, Charges in Excess of the Maximum Allowed Amount and Pharmacy Claims.		
• Individual	$2,500	$5,000
• Family	$5,000	$10,000
Your Plan has an Embedded Out-of-Pocket which means: • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If You also cover Dependents (other family members) under this Plan, both the "Individual" and "Family" amounts apply. The "Family" Out-of-Pocket amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Out-of-Pocket amount before the "Family" amount is met. You will never have to satisfy more than Your own 'Individual" Out-of-Pocket amount. If You meet Your "Individual" amount, other family member's claims will still accumulate towards their own "Individual" Out-of-Pocket and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Out-of-Pocket or the entire "Family" Out-of-Pocket is met.		
Amounts satisfied toward the Network Out-of-Pocket Maximum will be applied toward the Out-of-Network Out-of-Pocket Maximum and amounts satisfied toward the Out-of-Network Out-of-Pocket Maximum will be applied toward the Network Out-of-Pocket Maximum.		

SCHEDULE OF BENEFITS	NETWORK	OUT-OF-NETWORK
Note: Copayments apply to certain Network and Out-of-Network services. When a Copayment applies, that service is paid at 100% and all other services performed by same provider on same date of service are paid at applicable Deductible and Coinsurance.		
Allergy Care		
• Allergy Office Visit — Non-Specialist / Specialist Provider ➢ Coinsurance after Copayment • Allergy Testing and Treatment **Note:** Copayment is applied to office visit only.	$30 / $35 100% 80%	$50 / $55 100% 60%
ADD / ADHD		
• Attention Deficit Disorder (ADD) and Attention Hyperactivity Disorder (ADHD) Office Visit (Network Deductible Waived) ➢ Coinsurance after Copayment • All Other Assessment and Screening Services **Note:** Includes screening for autism, intellectual disability, developmental delays and learning disabilities.	$20 100% 80%	$30 100% 60%
Clinical Trials		
• Clinical Trials — Please see Clinical Trials under the **Benefits** section for further details.	Benefits are Paid Based on the Setting in which Covered Services are Received	Benefits are Paid Based on the Setting in which Covered Services are Received
Dental & Oral Surgery / TMJ Services		
• Accidental Injury to Natural and Sound Teeth ➢ Fluoride application for ages 0 – 6 is covered one per year, regardless of diagnosis and the prevention of dental caries for ages 0 – 6 is covered at 100%, regardless of diagnosis.	Covered at Benefit Level of Services Billed	Covered at Network Benefit Level of Services Billed
• Oral Surgery ➢ Includes removal of impacted teeth and osseous surgery. ➢ Dental anesthesia is covered only if related to a payable oral surgery.	80%	60%
• TMJ Treatment — Surgical and Non-Surgical Medical Treatment ➢ TMJ Appliance are covered and limited to 2 per Plan Year.	Covered at Benefit Level of Services Billed	Covered at Benefit Level of Services Billed

SCHEDULE OF BENEFITS	NETWORK	OUT-OF-NETWORK
Diagnostic Physician's Services		
• Office Visits / Home Visits / Consultations / Second Opinions Clinics – Non-Specialist / Specialist Provider	$30 / $35	$50 / $55
➢ Coinsurance after Copayment	80%	60%
• Retail Health Clinics	$20	$30
• Office Surgery	80%	60%
• Urgent Care (Office Setting)	$40	$60
• Anesthesia (Office Setting)	80%	60%
• Assistant Surgeon (Office Setting)	80%	60%
• Injections (Includes administration charge.)	80%	60%
• Diagnostic X-rays, Lab Tests (Office and Independent Lab Settings)	80%	60%
Note: Office visits for obesity are subject to Deductible and Coinsurance and Copayment is not applied.		
Important Note on Office Visits at an Outpatient Facility: If you have an office visit with your Primary Care Physician or Specialty Care Physician at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under the "Outpatient Facility" section earlier in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Emergency Care, Urgent Care and Ambulance Services		
• Emergency Room Institutional Services for an Emergency Medical Condition *(Copayment is waived if admitted.)*	$150	$150
➢ Coinsurance after Copayment.	80%	80%
• Emergency Room Physician Services for an Emergency Medical Condition	80%	80%
• Emergency Room Institutional Services for a Non-Emergency Medical Condition	$150	$150
➢ Coinsurance after Copayment.	80%	60%
• Emergency Room Physician Services for a Non-Emergency Medical Condition	80%	60%
• Urgent Care Professional Services (Deductible Waived)*	$40	$60
➢ Coinsurance after Copayment	100%	60%
• Urgent Care Institutional Services*	$30	$35
• Air and Land Ambulance Services (Deductible Waived)	80%	80%
➢ Claim payment may be contingent on review of Medical Necessity.		
*Urgent Care Copayment is applied to the first claim received either the Institutional or Professional claim.		

SCHEDULE OF BENEFITS	NETWORK	OUT-OF-NETWORK
Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		
Eye Care		
• Medical Eye Exam (For treatment of disease or Injury to the eye.) Deductible Waived — Non-Specialist / Specialist Provider	$30 / $35	$50/ $55
➢ Coinsurance after Copayment	80%	60%
• Glasses / Contacts after Cataract Surgery	80%	60%
Notes: Routine eye exams are covered at 100% up to age 21 with no limit.		
Hearing Care		
• Hearing Exam — Office and Outpatient Settings — Deductible Waived	100%	60%
➢ **Routine hearing exams are covered at 100% up to age 21.**	$30 / $35	$50 / $55
• Hearing Aid Assessment ➢ Coinsurance after Copayment	100%	60%
Note:		
Hearing Aids for accident, injury, or illness	80% No lifetime maximum	60% No lifetime maximum
Hearing aids for natural hearing loss	50% up to $1,000 lifetime maximum	50% up to $1,000 lifetime maximum
Home Health Care		
• Home Health Services — Limited to 180 days or 100 visits maximum per Plan Year; Network/Out-of-Network combined ➢ Private duty nursing is only covered in the home with no visit limits. ➢ Home infusion therapy does not count toward visit maximum.	80%	60%

Hospice Care		
• Hospice Services ➢ Includes respite care and bereavement counseling.	100%	100%
Hospital Inpatient Services		
• Institutional Inpatient Services — Precertification Required ➢ Room and board (Semi-private or ICU / CCU) ➢ Hospital services and supplies (X-ray and lab, anesthesia, surgery precertification required, Inpatient therapy services, maternity, etc.) • Inpatient Physical Medical Rehabilitation	80% 80%	60% 60%
• Professional Inpatient Services ➢ Surgeon ➢ Assistant Surgeon *(Covered if Medically Necessary.) ➢ Inpatient Medical Care (Includes general medical care, consultation/second opinion, and newborn care.) ➢ Anesthesiologist* ➢ Radiologist* ➢ Pathologist* *Hospital Based Provider Services Rendered by Non-Participating Providers are Covered at the Network Benefit Level.	80%	60%
Live Health Online: Online Telehealth Visits		
Live Health Online: Online Telehealth Visits	$10 Co-pay	N/A

Maternity Care & Other Reproductive Services		
• Global Care (Includes pre and post-natal delivery) ➢ Includes Therapeutic Abortions only. ➢ Network prenatal maternity care by office professional is covered at 100% and network Deductible is waived.	100%	60%
• Infertility Services — Covered for diagnosis of infertility only. (Treatment is not covered.) ➢ Non-Covered Services include in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination and reversal of voluntary sterilization.)	Covered at the Benefit Level of Services Billed	Covered at the Benefit Level of Services Billed
• Contraceptives (Services not included in Women's Health Provision) ➢ Covered devices include but are not limited to diaphragms, intrauterine devices and contraceptive implants.	100%	60%
• Sterilization Services (Services not included in Women's Health Provision) ➢ Vasectomy (Sterilizations and contraceptives for women will be covered under the "Preventive Care" benefit. Please see the **Benefits** section on page 33 for further details.) ➢ Reversal of voluntary sterilization is not covered.	100%	60%
Note: Precertification needed for childbirth if Inpatient stay exceeds 48 hours for normal delivery and 96 hours for cesarean delivery. Deductible is applied to mother's claim only for well newborn care.		
Medical Supplies and Equipment		
• Durable Medical Equipment (Purchase and Rental)	80%	60%
• Medical Supply	80%	60%
• Diabetic Supply ➢ Diabetic supplies covered by Your Pharmacy Plan are not covered under the medical plan including lancets, syringes, insulin, etc. ➢ Replacement batteries for infusion pumps owned by patient are not covered.	80%	60%
• Prosthetics and Orthotics ➢ Covered items include occlusal orthotic devices, braces for leg, arm, neck or back, trusses, back and special surgical corsets. ➢ Foot orthotics are covered for diagnosis of diabetes and diagnosis of accidental Injury.	80%	60%

Nutritional Counseling		
• Nutritional Counseling (Network Deductible is waived.) ➢ Services outside Health Care Reform (HCR) are limited to 2 visits per Plan year. ➢ For services that are a part of Health Care Reform, please refer to Preventive Care in the **Benefits** section. • Diabetic Education and Counseling	80% 80%	60% 60%
Obesity Services		
• Gastric Bypass / Obesity Surgery — When Medically Necessary. (Precertification Required) **Note:** Copayment is not applied to office visits for obesity diagnosis.	80%	60%
Outpatient Hospital / Facility Services		
• Institutional Outpatient Ambulatory Surgery • Outpatient Professional Services (Surgeon, anesthesiologist*, radiologist*, pathologist*, assistant surgeon* — covered only if Medically Necessary.)	80% 80%	60% 60%
• High Diagnostic Imaging* (Includes MRI, MRA, CAT, PET and SPECT) • Outpatient Clinic and Medical Institutional Services • Outpatient Professional Services • Institutional Outpatient Ambulatory Surgery • Pre-Surgical / Pre-Admission Testing *Hospital Based Provider Services Rendered by Non-Participating Providers Are Covered at the Network Benefit Level.	80% 80% 80% 80% 80%	60% 60% 60% 60% 60%
Preventive Services		
• Preventive Services due to Healthcare Reform ➢ Coinsurance for Preventive Services after Copayment • Counseling For Smoking and Tobacco Cessation. ➢ Coinsurance for Counseling for Smoking and Tobacco Cessation after Copayment	100% N/A 100% N/A	$30 100% $30 100%
Preventive Care for Chronic Conditions		
Medical items, equipment and screenings	Covered in full	Covered in full
Please refer to “Preventive Care for Chronic Conditions” in the **Benefits** section for details.		

Skilled Nursing Facility		
• Skilled Nursing Facility Services — Not Subject to Deductible ➢ First 180 days per Admission ➢ Subsequent Days *after the first 180 days*	 80% 60%	 80% 60%

Therapy Services (Outpatient)		
• Physical Therapy — Limited to 25 visits per Plan Year; Network/Out-of-Network combined; institutional /professional combined. Precertification is required after 25 visits.	80%	60%
• Speech Therapy — Limited to 25 visits per Plan Year; Network / Out-of-Network combined; Institutional / Professional combined. Precertification is required after 25 visits.	80%	60%
• Occupational Therapy — Limited to 25 visits per Plan Year; Network / Out-of-Network combined; Institutional / Professional combined. Precertification is required after 25 visits.	80%	60%
• Radiation Therapy	80%	60%
• Blood Therapy (Processing and Storage)	80%	60%
• Infusion Therapy	80%	60%
• Vision Therapy	80%	60%
• Respiratory Therapy	80%	60%
• Cardiac Rehabilitation	80%	60%
• Chemotherapy	80%	60%
• Dialysis / Hemodialysis	80%	60%
• Manipulation Therapy — Visits are unlimited; however, precertification is required after 25 visits. ➢ Includes but not limited to office visits, physical treatments, hydrotherapy, heat or similar methods, physical agents, biomechanical and neurophysiological principles. Braces and molds are not covered.	80%	60%
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		

TRANSPLANT SCHEDULE OF BENEFITS	BDCT FACILITY	NETWORK	OUT-OF-NETWORK
Transplants — Precertification is required. Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by Anthem including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy. **The Blues Distinction Center for Transplant (BDCT) Facility/Center of Excellence requirements do not apply to** Cornea and kidney transplants and any Covered Services related to a Covered Transplant Procedure received prior to or after the Transplant Benefit Period. **Note:** Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact Anthem to determine which Hospitals are Network Transplant Providers. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.)			
• Organ Transplants — Institutional and Professional Services ➢ Donor expenses are covered at BDCT Facility.	80%	80%	60%
• Live Donor Health Services ➢ Benefits necessary for obtaining an organ from a living donor or cadaver are provided. Donor benefits are provided and processed under the transplant recipient's coverage only and are subject to any applicable limitations and exclusions. Includes kidney, cornea, bone marrow, heart, heart and lung, liver and pancreas. Additional transplants considered for coverage provided that the transplant is Medically Necessary.	80%	80%	60%
• Bone Marrow Donor Search Fee	80%	80%	60%
• Travel and Lodging for Organ Transplants	Not Covered	Not Covered	Not Covered

TOTAL HEALTH AND WELLNESS SOLUTIONS

24/7 NurseLine

You may have emergencies or questions for nurses around the clock. 24/7 NurseLine provides You with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number. You can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- A skilled clinical team – RN license (BSN preferred) that helps Members assess systems, understand medical conditions, ensure Members receive the right care in the right setting and refer You to programs and tools appropriate to Your condition.
- Bilingual RNs, language line and hearing impaired services.
- Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics.
- Proactive callbacks within 24 to 48 hours for Members referred to 911 emergency services, poison-control and pediatric Members with needs identified as either emergent or urgent.
- Referrals to relevant community resources.

Anthem Health Guide

Anthem Health Guide provides You with enhanced member services support. You can contact a health guide with questions about benefits, programs for Your health, help scheduling doctor's appointments, comparing costs for procedures, and more. Health guides can connect You with knowledgeable health professionals to help You manage chronic conditions, deal with an illness, or provide support for emotional concerns like anxiety or depression. Reach out to Member Services and our health guides via phone, email, app, or even chat online.

ConditionCare Programs

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

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

You will receive:

- 24/7 phone access to a nurse coach who can answer Your questions and give You up-to-date information about Your condition.
- A health review and follow-up calls if You need them.

Tips on prevention and lifestyle choices to help You improve Your quality of life.

Future Moms

The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special

management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches supported by pharmacists, registered dietitians, social workers and medical directors. You will receive:

- 24/7 phone access to a nurse coach who can talk with You about Your pregnancy and answer Your questions.
- *Your Pregnancy Week by Week*, a book to show You what changes You can expect for You and Your baby over the next nine months.

Useful tools to help You, Your Physician and Your Future Moms nurse coach track Your pregnancy and spot possible risks.

MyHealth Advantage

MyHealth Advantage is a free service that helps keep You and Your bank account healthier. Here's how it works: the Claims Administrator will review Your incoming health claims to see if the Plan can save You any money. The Claims Administrator can check to see what medications You are taking and alert Your Physician if the Claims Administrator spot a potential drug interaction. The Claims Administrator also keeps track of Your routine tests and checkups, reminding You to make these appointments by mailing You MyHealth Notes. MyHealth Notes summarize Your recent claims. From time to time, the Claims Administrator will offer tips to save You money on Prescription Drugs and other health care supplies.

ELIGIBILITY

Coverage for the Employee

This Benefit Booklet describes the benefits an Employee may receive under this Health Care Plan. The Employee is also called a Subscriber.

Eligibility Requirements

Employee Eligibility

You are eligible for health care benefits if You are a permanent full-time Employee, permanent part-time Employee, or a part-time temporary Employee who averages at least 30 hours of service per week over a twelve-month measurement period.

State of Ohio Employee health plans do not contain pre-existing condition exclusions; therefore, coverage is available to You and Your eligible Dependents regardless of current health or health history.

Married State Employees

When both Spouses in a family are employed by the State, each may elect single coverage, or one may elect family coverage provided that the Spouse who elects single coverage may not be listed as a Dependent under the family coverage. A child who is eligible as an Employee of the State is not also eligible as the Dependent of a parent who is also a State Employee, except as required by the PPACA.

Dependent Eligibility

Family members as described below may be eligible for coverage under Your medical coverage:
(Please go to: das.ohio.gov/eligibility requirements for the Definitions and Required Documents checklist for documentation required to enroll a Dependent).

1. Spouse. You current legal Spouse as recognized by Ohio law.
2. Children Under Age 26 including:
   - Your biological children (married or unmarried)
   - Your legally adopted children; adopted children have the same coverage as children born to You or Your Spouse., whether or not the adoption has been finalized. Coverage begins upon placement/custody for adoption.
   - Your dependent stepchildren
   - Foster children
   - Children for whom either You or Your Spouse has been appointed legal guardian
   - Children for whom the Plan has received a Qualified Medical Child Support Order: the child must be named as Your alternate recipient in the QMCSO

   Note: Dependent children are only eligible for dental/vision benefits if unmarried and under age 23. Dependent children ages 19-22 with dental/vision coverage must be a student.
3. Unmarried Children Incapable of Self Care

   Unmarried children who are incapable of self-support due to intellectual impairment, severe mental illness, or physical disability, whose impairment began before age 23 and who are primarily dependent upon You are eligible for coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be re-enrolled for coverage, provided that the application is submitted within five (5) years following loss of coverage.

   This coverage is not automatic. You must complete the applicable form for this Plan. The form can be found at das.ohio.gov/healthplanforms.

   Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

Examples of Persons NOT Eligible for Coverage as a Dependent:

- A Spouse from whom the Employee is legally divorced or legally separated
- Children who are age 26 and older
- Live-in boyfriends or girlfriends
- Parents or parents-in-law
- Grandchildren (unless Employee is the court-appointed legal guardian)
- Adults who are not the Employee's or Spouse's child under guardianship of Employee (brother, sister, aunt, uncle, etc.)
- A Spouse from a common law marriage established in Ohio after October 10, 1991
- Any other members of Your household who do not meet the definition of an eligible Dependent
- A child who is eligible as an Employee of the State is not also eligible as the Dependent of a parent who is also a State Employee.

It is the Employee's responsibility to dis-enroll a family member who is no longer eligible for coverage.

Knowingly providing false or misleading Dependent eligibility information may result in any or all of the following actions by the State of Ohio: 1) loss of coverage; 2) disciplinary action, up to and including removal; 3) collection action to recoup payments of benefits and claims paid for individuals determined to be ineligible Dependents; and/or 4) civil and/or criminal prosecution.

Child Support Order

In general, a medical child support order is a court order that requires an Eligible Employee to provide medical coverage for his or her children in situations involving divorce, legal separation or paternity dispute. A medical child support order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except as otherwise required by law. This Plan provides benefits according to the requirements of a medical child support order that is entered by a court of competent jurisdiction or by a local child support enforcement agency. The Group will promptly notify affected Card Holders if a medical child support order is received. The Group will notify these individuals of its procedures for determining whether medical child support orders meet the requirements of the Plan; within a reasonable time after receipt of such order, the Group will determine whether the order is acceptable and notify each affected Card Holder and of its determination. Once the dependent child is enrolled under a medical child support order, the child's appointed guardian will receive a copy of all pertinent information provided to the Eligible Employee. In addition, should the Eligible Employee lose eligibility status, the guardian will receive the necessary information regarding the dependent child's rights for continuation of coverage under COBRA.

Effective Date

Coverage starts at 12:01 a.m. on the Effective Date. The Effective Date is typically the first day of the month following your hire date. The effective date for enrollment or changes made during open enrollment is typically July 1. No benefits will be provided for services, supplies or charges Incurred before Your Effective Date.

Changes in Coverage

If You have individual coverage, You may change to family coverage if You marry or You or Your Spouse acquire an Eligible Dependent. You must notify Your benefits specialist who must then notify Anthem of the change.

Coverage for a Spouse and other Dependents who become eligible by reason of marriage will be effective on the first of the month following the date of the marriage if a request for their coverage is submitted to the Group within 31 days of the marriage. A newborn child or an adopted child will be covered as of the date of birth or adoptive placement, provided that You request enrollment within 31 days of the date of birth or adoptive placement. Coverage will continue for an adopted child unless the placement is disrupted prior to legal adoption and the child is removed from placement.

It is important to complete and submit Your Enrollment Form promptly.

There are occasions when circumstances change and only the Card Holder is eligible for coverage. Family coverage must then be changed to individual coverage. In addition, the Group must be notified when You or an Eligible Dependent under Your Benefit Book becomes eligible for Medicare

Special Enrollment
For information regarding eligible changes outside of open enrollment, please go to the State of Ohio's website at: http://das.ohio.gov/benefits and click the link on the right entitled "Change In Status/Qualifying Events Matrix".

FOR OP&F DEATH BENEFIT FUND RECIPIENTS ONLY
Most OP&F Death Benefit Fund Recipients are eligible for medical coverage effective the first day of the month following the receipt of the application for death benefit funds or if they experience a change in status/qualifying event. Dependents are eligible for medical coverage up to the age of 26. See Pages 4 and 5 for more details. Coverage may be continued after age 26 if the dependent qualifies as disabled.

DEPENDENT ELIGIBILITY
Family members described below may be eligible for coverage under your health benefits package.
Note: Dependent children are only eligible for dental and vision benefits if unmarried and younger than age 22; however, dependent children ages 19 through 22 must be students.
Documentation will be required at the time of dependent enrollment to verify eligibility.

1. **Children younger than age 26 including your biological children (married or unmarried).**

2. **Unmarried children incapable of self-care.** Unmarried children who are incapable of self-support due to a qualifying developmental disability, severe mental illness or physical handicap, whose disability began before age 23 and who are primarily dependent upon you are eligible for medical coverage. When there is an unsuccessful attempt at independent living, a child covered pursuant to this provision may be reenrolled for coverage, provided that the application is submitted within five years following loss of coverage.

This coverage is not automatic. You must complete the applicable form for your third-party administrator of the Ohio Med PPO. A form for each third-party administrator can be obtained from the DAS Employee Benefits Management Team at 1-800-409-1205, option 2.
Periodically, but not more than once a year, proof of continued incapacity and dependence must be provided upon request.

Examples of persons not eligible for coverage as a dependent include, but are not limited to:
- A spouse;
- Live-in boyfriend or girlfriend;
- Parents or parents-in-law;
- Grandchildren (unless the OP&F Death Benefit Fund Recipient is the court-appointed legal guardian)
- Adults who are not the OP&F Death Benefit Fund Recipient's children under guardianship of OP&F Death Benefit Fund Recipient (brother, sister, aunt, uncle, etc.);
- Any other members of your household who do not meet the definition of an eligible dependent;
- A child who is eligible as an OP&F Death Benefit Fund Recipient of the State of Ohio is not eligible as the dependent of a parent who also is a State of Ohio OP&F Death Benefit Fund Recipient; and
- A child of an OP&F Death Benefit Fund Recipient cannot also be covered as the spouse of another OP&F Death Benefit Fund Recipient or an employee enrolled in the State of Ohio health plan.

HOW YOUR PLAN WORKS

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

Introduction

Your health Plan is a Preferred Provider Organization (PPO) which is a comprehensive Plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

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

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

Network Services

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

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

To see a Doctor, call their office:

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

When You go to the office, be sure to bring Your Member Identification Card with You.

For services from Network Providers:

1. You will not need to file claims. Network Providers will file claims for Covered Services for You. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by Your In-Network Provider(s) for any non-Covered Services You get or when You have not followed the terms of this Benefit Booklet.
2. Precertification will be done by the Network Provider. (See the **Health Care Management - Precertification**" section for further details.)

Please read the **Error! Reference source not found.** section for additional information on Authorized S ervices.

After Hours Care

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

Out-of-Network Services

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

For services from an Out-of-Network Provider:

- The Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount (balance billing) plus any Deductible and / or Coinsurance / Copayments;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see **Health Care Management – Precertification** for more details.)

How to Find a Provider in the Network

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

- See Your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with Your Doctor or Provider.

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

The BlueCard Program

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

Copayment

Certain Network services may be subject to a Copayment amount which is a flat-dollar amount You will be charged at the time services are rendered.

Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the **Schedule of Benefits**. Unless otherwise indicated, services which are not specifically identified in this Benefit Booklet as being subject to a Copayment are subject to the **Plan Year Deductible** and payable at the **percentage payable** in the **Schedule of Benefits.**

Plan Year Deductible

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

HEALTH CARE MANAGEMENT – PRECERTIFICATION

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Benefit 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.

Acute Care at Home Programs

Anthem has programs available that offer acute care to Members where they live as an alternative to staying in a Facility, when the Member's condition and the Covered Services to be delivered, are appropriate for the home setting. We refer to these programs as Acute Care at Home Programs. These programs provide care for active, short-term treatment of a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. Acute care services are generally delivered by teams of health care Providers from a range of medical and surgical specialties. The Acute Care at Home Programs are separate from our Home Care Services benefit, are only available in certain Service Areas, and are only provided if the Member's home meets accessibility requirements.

Covered Services provided by Acute Care at Home Programs may include Physician services (either in-person or via telemedicine), diagnostic services, surgery, home care services, home infusion therapy, Prescription Drugs Administered by a Medical Provider, therapy services, and follow-up care in the community. Prescription Drugs at a Retail or Mail Order Pharmacy are not included in these Programs. Acute Care at Home Programs may also include services required to set up telemedicine technology for in-home patient monitoring, and may include coverage for meals.

Members who qualify for these programs will be contacted by our Provider, who will discuss how treatment will be structured, and what costs may be required for the services. Benefit limits that might otherwise apply to outpatient or home care services, (e.g., home care visits, physical therapy, etc.), may not apply to these programs.

Your participation in these programs is voluntary. If You choose to participate, Your Provider will discuss the length of time that benefits are available under the program (e.g., the Acute Care at Home Benefit Period) when You enroll. The Acute Care at Home Benefit Period typically begins on the date Your Acute Care at Home Provider sets up services in Your home, and lasts until the date You are discharged from the Program.

Any Covered Services received before or after the Acute Care at Home Benefit Period will be covered according to the other benefits of this Plan.

Reviewing Where Services are Provided

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

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

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Plan may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate. "Clinically equivalent" means treatments that for most Members will give You similar results for a disease or condition.
If You have any questions about the Utilization Review process, the medical policies, or clinical guidelines, You may call the Member Services telephone number on Your Identification Card or visit www.anthem.com.

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

1. You must be eligible for benefits;
2. fees must be paid for the time period that services are given;
3. the service or supply must be a Covered Service under 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

- **Precertification –** A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. Please contact us at the customer service telephone number on the back of your Identification Card to determine if a Prior Authorization or a precertification is required. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / 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.

If you fail to get Precertification, your claim will be reviewed for coverage after it is received by us to determine if your service, treatment, admission or Prescription Drug is Medically Necessary and a Covered Service on the date you get it. As noted in the "Reviewing Where Services Are Provided" section above, coverage for or payment of the service or treatment is not guaranteed even if the Plan decides your services are Medically Necessary. On the date you get services you must be eligible for benefits; your Fees must be paid; the service or supply must be a Covered Service; the service cannot be subject to an Exclusion under this Booklet; and you must not have exceeded any applicable limits under your Plan. Additionally, your claim must be received by us within the timeframes specified in the Notice of Claim & Proof of Loss provision in the Claims Payment section of this Booklet. Please note that if the Covered Service is received from an Out-of-Network Provider or a provider that is not authorized by us (gene therapy), you may also still be liable for all or part of the claim.

- **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 will 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. Either you, the treating Provider or any Physician with knowledge of your medical condition can request an urgent pre-service or urgent continued stay/concurrent review of a

service, treatment or admission for a benefit coverage determination, including for a Prescription Drug that is going to be used for the treatment of opioids. Please note that where a pre-service or continued stay/concurrent review request is required for Medication Assisted Treatment for the treatment of opioids, such requests will be considered urgent. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review –** A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us. An example of a type of post-service review is a retrospective post-claim review. For retrospective reviews if you send us a written request, the Plan will permit a retrospective review for a claim that is submitted where prior approval was required but not obtained if the service in question meets all of the following:

  a. The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
  b. The new service was not known to be needed at the time the original prior authorized service was performed.
  c. The need for the new service was revealed at the time the original authorized service was performed.

  Once the Plan receives the written request and all necessary information we will review the claim for coverage and Medical Necessity. The Plan will not deny a claim for such a new service based solely on the fact that we did not receive a prior approval for the new service in question.

Precertification Penalties:

- **No Precertification on File** – If claims are not precertified, they will be denied for no precertification. Once information is received claims can be reopened based on medical information provided.
- **Not Medically Necessary** – Any services or days found not be Medically Necessary will not be covered.
- **Late Notice / Penalty Amount** – A $350 penalty is applied to Out-of-Network Inpatient Hospital services that are not precertified.

The following list is not all inclusive and is subject to change; please call the Member Services at 1.844.891.8359 to confirm the most current list and requirements for Your Plan.

Inpatient Admission:

- Inclusive of all Acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehab, and OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)
- Emergency Admissions (Requires Plan notification no later than 2 business days after admission)

Outpatient and Surgical Services:

- Air Ambulance (excludes 911 initiated emergency transport)
- Bone-Anchored and Bone Conduction Hearing Aids
- Cochlear Implants and Auditory Brainstem Implants
- Corneal Collagen Cross-Linking
- Cryopreservation of Oocytes or Ovarian Tissue
- Diaphragmatic/Phrenic Nerve Stimulation pacing systems
- Deep Brain, Cortical, and Cerebellar Stimulation
- Electric Tumor Treatment Field (TTF) for treatment of glioblastoma
- Immunoprophylaxis for respiratory syncytial virus (RSV)
- Implantable Middle Ear Hearing Aids
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Occipital nerve stimulation
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Photocoagulation of Macular Drusen
- Private Duty Nursing
- Presbyopia and Stigmatism – Correcting Intraocular Lenses
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia
- Treatment of Hyperhidrosis
- Treatments for Urinary Incontinence
- Transcatheter Uterine Artery Embolization
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation

Diagnostic Testing:

- Cardiac Ion Channel Genetic Testing
- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Genetic Testing for Breast and/or Ovarian Cancer Syndrome
- Genetic Testing for Cancer Susceptibility
- Preimplantation Genetic Diagnosis Testing
- SmartPill™ Motility Testing
- Prostate Saturation Biopsy

Durable Medical Equipment (DME)/Prosthetics:

- Augmentative and Alternative Communication (AAC) Devices/ Speech Generating Devices (SGD)
- Continuous Interstitial Glucose Monitoring
- Custom-made Knee Braces

- Dynamic Low-Load Prolonged-Duration Stretch Devices (LLPS)
- Electrical Bone Growth Stimulation
- External (Portable) Continuous Insulin Infusion Pump
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
- Implantable Infusion Pumps
- Lower Limb Prosthesis and Microprocessor Controlled Lower Limb Prosthesis
- Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
- Pneumatic Compression Devices for Lymphedema
- Ultrasound Bone Growth Stimulation
- Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)
- Prosthetics: Electronic or externally powered and select other prosthetics- (myoelectric-UE)
- Standing Frame
- Transtympanic Micropressure for the Treatment of Ménière's Disease

Radiation Therapy/Radiology Services:

- Intensity Modulated Radiation Therapy (IMRT)
- Magnetic Source Imaging and Magnetoencephalography (MSI/MEG)
- Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
- Proton Beam Therapy
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for treating Primary or Metastatic Liver Tumors
- Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Malignant Lesions Outside the Liver- except CNS and Spinal Cord
- Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule

Surgical Services:

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Balloon and Self-Expanding Absorptive Sinus Ostial Dilation
- Bariatric Surgery and Other Treatments for Clinically Severe Obesity
- Bronchial Thermoplasty for Treatment of Asthma

Cardio-Vascular:

- ► Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- ► Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- ► Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
- ► Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- ► Implantable or Wearable Cardioverter-Defibrillator
- ► Maze Procedure

- ► Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- ► Mechanical Embolectomy for Treatment of Acute Stroke
- ► Partial Left Ventriculectomy
- ► Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- ► Transcatheter Heart Valve Procedures
- ► Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
- ► Treatment of Varicose Veins (Lower Extremities)
- ► Venous Angioplasty with or without Stent Placement/ Venous Stenting

- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Lung Volume Reduction Surgery
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies

Musculo-Skeletal Surgeries:

- ► Axial Lumbar Interbody Fusion
- ► Cervical Total Disc Arthoplasty
- ► Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- ► Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- ► Implanted Devices for Spinal Stenosis
- ► Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- ► Lumbar Discography
- ► Lumbar Laminectomy, Hemi-Laminectomy, Laminotomy and/or Discectomy
- ► Lumbar Spinal Fusion and Lumbar Total Disc Arthroplasty
- ► Lysis of Epidural Adhesions
- ► Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- ► Meniscal Allograft Transplantation of the Knee
- ► Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- ► Sacroiliac Joint Fusion
- ► Surgical Interventions for Scoliosis and Spinal Deformity
- ► Total Ankle Replacement
- ► Treatment of Osteochondral Defects of the Knee and Ankle
- ► Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome

Plastic/Reconstructive surgeries/treatments:

- ► Abdominoplasty ,Panniculectomy, Diastasis Recti Repair
- ► Blepharoplasty
- ► Brachioplasty
- ► Breast Procedures; including Reconstructive Surgery, Implants and other Breast Procedures
- ► Buttock/Thigh Lift
- ► Chin Implant, Mentoplasty, Osteoplasty Mandible

- ► Composite Products for Wound Healing and Soft Tissue Grafting
- ► Insertion/Injection of Prosthetic Material Collagen Implants
- ► Hyperbaric Oxygen Therapy (Systemic/Topical)
- ► Liposuction/Lipectomy
- ► Mandibular/Maxillary (Orthognathic) Surgery
- ► Mastectomy for Gynecomastia
- ► Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- ► Penile Prosthesis Implantation
- ► Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
- ► Procedures Performed on Male or Female Genitalia
- ► Procedures Performed on the Trunk and Groin
- ► Reduction Mammaplasty
- ► Repair of Pectus Excavatum / Carinatum
- ► Rhinoplasty
- ► Septoplasty
- ► Skin-Related Procedures

- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Surgical and Ablative Treatments for Chronic Headaches
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Transanal Hemorrhoidal Dearterialization (THD)
- Surgical Treatment of Obstructive Sleep Apnea and Snoring
- Viscocanalostomy and Canaloplasty

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
  - ► Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
  - ► Donor Leukocyte Infusion
- (CAR) T-cell immunotherapy treatment
- Gene replacement therapy intended to treat retinal dystrophies
- Intrathecal treatment of Spinal Muscular Atrophy (SMA)

<u>Out-of-Network Referrals:</u>

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

The following services do not require precertification, but are recommended for pre-determination of Medical Necessity due to the existence of post service claim review criteria and/or the potential cost of services to the Member if denied for lack of Medical Necessity**: Procedures, equipment, and/or specialty infusion drugs which have Medically Necessary criteria determined by the Claims Administrator's Medical Policy or Clinical Guidelines.**

Who is Responsible for Precertification?
Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with the Claims Administrator to ask for a Precertification. However, You may request a Precertification or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances. **Please contact us at the customer service telephone number on the back of your Identification Card to determine if a Prior Authorization or a precertification is required. You can find the list of medical services that require Precertification here: https://www.anthem.com/provider/prior-authorization/. Prescription Drugs requiring Precertification can be found in the formulary list here: https://www11.anthem.com/pharmacyinformation/. You should log into your member account to find out the correct formulary to select specific to your Plan.**

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

Anthem will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines, and other applicable policies and procedures to assist in making Medical Necessity decisions. Anthem reserves the right to review and update these clinical coverage guidelines periodically. The State's Plan takes precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to Your request. To request this information, contact the Member Services telephone number on Your Identification Card.

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

In addition, Anthem may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. Anthem 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 modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by contacting Member Services at 1.844.891.8359.

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

Request Categories:

- **Urgent –** a request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the Member to severe pain that cannot be adequately managed without such care or treatment.
- **Prospective –** a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent/Continued Stay Review -** a request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective -** a request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review is also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on Your Identification Card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent/Continued Stay Review when hospitalized at time of request	72 hours from request and prior to expiration of current certification
Other Concurrent/Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Continued Stay Review Urgent when request is received less than 24 hours before the expiration of the previous	72 hours from the receipt of the request

authorization or no previous authorization exists	
Concurrent Continued Stay Review Non-Urgent for ongoing outpatient treatment	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make a decision, the Claims Administrator will notify the requesting Provider of the specific information necessary to complete the review. If the Claims Administrator does not receive the specific information requested by the required timeframe, a decision will be made based upon the information in the Claims Administrator's possession.

The Claims Administrator will notify you and your Provider of a decision in accordance with federal regulations. Notification may be given by one or more of the following methods: verbal, written, and/or electronic.

Once a pre-service review is approved, it will not be retroactively denied, except in cases of fraudulent or materially incorrect information, when all of the following are met:

- The Provider submits a prior approval request to the Claims Administrator for a health care service, drug, or device;
- The Plan approves the prior approval request after determining that all of the following are true:
  1. The patient is eligible under this Plan.
  2. The health care service, drug, or device is covered under this Plan.
  3. The health care service, drug, or device meets our standards for Medical Necessity and prior authorization.
- The Provider renders the health care service, drug, or device pursuant to the approved prior approval request and all of the terms and conditions of the Provider's contract with the Claims Administrator;
- On the date the health care practitioner renders the prior approved health care service, drug, or device, all of the following are true:
  1. The patient is eligible under this Plan.
  2. The patient's condition or circumstances related to their care has not changed.
  3. The Provider submits an accurate claim that matches the information submitted by the Provider in the approved prior approval request.
- If the Provider submits a claim that includes an unintentional error and the error results in a claim that does not match the information originally submitted by the Provider in the approved prior authorization request, upon receiving a denial of services from the Plan, the Provider may resubmit the claim with the information that matches the information included in the approved prior approval.

Electronic Submission of Pre-service reviews

If the request for a Pre-service Review of a health care service, device, or drug is submitted to the Claims Administrator electronically from your Provider, the Plan will respond:

- Within forty-eight (48) hours of the time the request is received if it's for Urgent Care Services;
- Within ten (10) calendar days of the time the request is received if it's for non Emergency or non-Urgent Care Services.

The Plan's response will state if the request is approved or denied. If denied, the Plan will provide the specific reason for the denial. If incomplete, the Plan will indicate the specific additional information that is required to process the request. If the Claims Administrator requests additional information required to process the request, your Provider must provide an electronic receipt to the Claims Administrator acknowledging that the request for additional information was received. If additional information is needed to process a request for Urgent Care Services, the Plan will notify the health care practitioner within 24 hours of receipt of the claim involving Urgent Care. Because we are required to make a decision within 48 hours after receipt of the claim involving Urgent Care, your claim may still be denied when we request additional information.

Please note that an External Review under the Complaint and Appeals Procedures section of this Benefit Booklet is also available under this option.

For purposes of this section only, Urgent Care Services means medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
- In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of a Pre service Review request as outlined in the Getting Approval for Benefits section of this Plan.

This section does not apply to Emergency services.

Electronic Submission of Pre-service reviews

If the request for a Pre-service Review of a health care service, device, or drug is submitted to the Claims Administrator electronically from your Provider, the Plan will respond:

- Within forty-eight (48) hours of the time the request is received if it's for Urgent Care Services;
- Within ten (10) calendar days of the time the request is received if it's for non Emergency or non-Urgent Care Services.

The Plan's response will state if the request is approved or denied. If denied, the Plan will provide the specific reason for the denial. If incomplete, the Plan will indicate the specific additional information that is required to process the request. If the Claims Administrator requests additional information required to process the request, your Provider must provide an electronic receipt to the Claims Administrator acknowledging that the request for additional information was received.

Please note that the appeals procedures under the **Your Right to Appeal** section of this Benefit Booklet are also available under this option.

For purposes of this section only, Urgent Care Services means medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;
- In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of a Pre service Review request as outlined in the **Health Care Management - Precertifiation** section of this Plan.

This section does not apply to Emergency services.

Health Plan Individual Case Management

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

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

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

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

BENEFITS

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details. All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.

Ambulance Service

Medically Necessary ambulance services are a Covered Service when:

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

And one or more of the following criteria are met:

For ground ambulance, You are taken:

- From Your home, the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when Anthem requires You to move from an Out-of-Network Hospital to a Network Hospital
- Between a Hospital and a Skilled Nursing Facility or other approved Facility.

For air or water ambulance, You are taken:

- From the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when Anthem requires You to move from an Out-of-Network Hospital to a Network Hospital;
- Between a Hospital and an approved Facility.

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

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

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

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

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

Other non-covered Ambulance Services include, but are not limited to, trips to:

- A Doctor's office or clinic;
- Your home;
- A morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger Your health and Your medical condition requires

a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

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

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

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

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

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

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

Clinical Trials
Benefits include coverage for services, such as routine patient care costs, 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 a Network Provider to maximize Your benefits.

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

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

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

1. The Experimental/Investigative item, device, or service; or
2. Items and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial

Please note that under Ohio state law, to qualify for coverage, you do not have to:

1. Have the reference of a participating health professional; or
2. Provide appropriate medical and scientific information.

Consultation Services

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

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

Dental Services

Related to Accidental Injury

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

Other Dental Services

Your Plan also includes benefits for hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:

- The Member has a severe impairment that requires hospitalization or general anesthesia for dental care; or

- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

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

Dialysis Treatment
The Plan covers Covered Services for Dialysis treatment.

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

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

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

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

Emergency Services
Emergency Care benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means a medical or behavioral health condition that manifests itself by such acute symptoms of sufficient severity, including severe pain that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

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

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

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

Emergency Care

“Emergency Care” means a medical or behavioral health exam done in the Emergency Department of a Hospital, 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.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of the following:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method the Claims Administrator generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient’s presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copayment/Coinsurance for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify the Claims Administrator, on behalf of the Employer, or verify that your Physician has notified the Claims Administrator of your admission within 24 hours or as soon as possible within a reasonable period of time. When the Claims Administrator is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Claims Administrator, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with the Claims Administrator or is a BlueCard

Provider, you will be financially responsible for any care the Claims Administrator, on behalf of the Employer, determines is not Medically Necessary.

Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from an Out-of-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as an Out-of-Network service unless the Claims Administrator authorizes the continuation of care and it is Medically Necessary.

General Anesthesia Services

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

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

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

Habilitative Services

Benefits also include habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living. 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.

Hearing Aids

Hearing Aids are covered for accident, injury, or illness with no lifetime maximum. Hearing Aids for natural hearing loss are subject to a lifetime maximum. Refer to your schedule of benefits for any dollar limitations.

Home Health Care Services

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

Some special conditions apply:

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

Covered Services:

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

- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do not include:

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

Hospice Care Services

You are eligible for Hospice care if Your Doctor and the Hospice medical director certify that You are terminally ill. You may access Hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying terminal illness.

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

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

Your Doctor and Hospice medical director must certify that You are terminally ill and likely have less than 12 months to live. 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 Anthem upon request.

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

Hospital Services

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

Network

Inpatient Services

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

Services and Supplies

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

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

Hospital Benefits

- If You are confined in an Out-of-Network Hospital, Your benefits are the same as Network but Your financial responsibility will be significantly increased, as explained in the **Schedule of Benefits** section

Hospital Visits

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

Human Organ and Tissue Transplant Services

Notification

To maximize Your benefits, You need to call Anthem's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.

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

Covered Transplant Benefit Period

At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility. At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification
In order to maximize Your benefits, Anthem strongly encourages You to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Anthem will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact Member Services at 1.844.891.8359 **and ask for the transplant coordinator.** Even if Anthem issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call Anthem's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

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

Licensed Speech Therapist Services
Services must be ordered and supervised by a Physician as outlined in the **Schedule of Benefits**.

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

Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well baby pediatrician visits performed in the Hospital.

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

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

Abortion (Therapeutic) − Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape.

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

Infertility Services
Your Plan also includes benefits for the diagnosis of infertility. Covered Services include diagnostic and exploratory procedures to determine whether a Member suffers from infertility. This includes surgical procedures to correct any diagnosed disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure. See **Schedule of Benefits** for benefit limitations.

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

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

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

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

Oral Surgery
Covered Services include only the following:
- Fracture of facial bones;
- Removal of impacted teeth;
- Lesions of the mouth, lip, or tongue which require a pathological exam;
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Covered Services do **not** include fixed or removable appliances which involve movement or repositioning of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures);
- Plastic repair of the mouth or lip necessary to correct traumatic Injuries or congenital defects that will lead to functional impairments; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily Injury to sound natural teeth or structure occurring while a Member is covered by this Plan.

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

Other Covered Services
Your Plan provides Covered Services when the following services are Medically Necessary:
- Chemotherapy and radioisotope, radiation and nuclear medicine therapy;
- Diagnostic x-ray and laboratory procedures;
- Dressings, splints, casts when provided by a Physician;

- Oxygen, blood and components, and administration;
- Pacemakers and electrodes;
- Use of operating and treatment rooms and equipment.

Online Visits

When available in Your area, Your coverage will include online visits. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Non-Covered Services include, but are not limited to, communications used for:

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

Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

Outpatient Hospital Services

The Plan provides Covered Services when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

Outpatient Surgery

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

Physical Therapy, Occupational Therapy, Manipulation Therapy

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

Physician Services

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

Preventive 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). This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when You use a Network Provider.

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

Covered Services fall under the following broad groups:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
   a. Breast Cancer;
   b. Cervical Cancer;
   c. Colorectal Cancer;
   d. High Blood Pressure;
   e. Type 2 Diabetes Mellitus;
   f. Cholesterol;
   g. Child and Adult Obesity.

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

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

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

Women’s contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
   a. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
   b. Gestational diabetes screening.

You may call Member Services at 1.844.891.8359 for additional information about these services. (or view the federal government’s web sites, http://www.healthcare.gov/center/regulations/prevention.html, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

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

- Routine screening mammograms. The total benefit for a screening mammography under this Plan, regardless of the number of claims submitted by Providers, will not exceed one hundred thirty per cent (130%) of the Medicare reimbursement rate in the state of Ohio for a screening mammography. If a Provider, Hospital, or other health care facility provides a service that is a component of the screening mammography and submits a separate claim for that component, a separate payment shall be made to the Provider, Hospital, or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. The benefit paid for mammography constitutes full payment under this Plan. No Provider, Hospital, or other health care facility shall seek or receive compensation in excess of the payment made that corresponds to the ratio paid by Medicare in Ohio.

- Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test).

Child health supervision services from the moment of birth until age nine. Child health supervision services mean periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of hearing screening, by an individual acting in accordance with Ohio law. Periodic review means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

Prosthetic Appliances

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

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

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

Reconstructive Surgery

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

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

Retail Health Clinic

Benefits are provided for Covered Services received at a Retail Health Clinic.

Skilled Nursing Facility Care

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

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

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

Covered Services include:

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

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

Benefits will not be provided when:

- a Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;

- no specific medical conditions exist that require care in a Skilled Nursing Facility; or
- the care rendered is for other than Skilled Convalescent Care.

Surgical Care

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

Treatment of Accidental Injury in a Physician's Office

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

LIMITATIONS AND EXCLUSIONS

In addition to the exclusions and limitations explained elsewhere in this book, coverage is not provided for the following services and supplies.

1. **Abortions –** For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than: as a therapeutic abortion (abortion recommended by a Provider) performed to save the life or health of the mother, or as a result of incest or rape; or miscarriage due to a spontaneous abortion (occurs naturally and suddenly).
2. **Admissions for Non-Inpatient Services -** Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
3. **Administrative Charges -** Charges for any of the following:
   a. Failure to keep a scheduled visit;
   b. Completion of claim forms or medical records or reports unless otherwise required by law;
   c. For Physician or Hospital's stand-by services;
   d. For holiday or overtime rates.
   e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to Provider their test results.
   f. Specific medical reports including those not directly related to the treatment of the Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
4. **Allergy Services -** Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
5. **Alternative Therapies –** Hypnotherapy, acupuncture and acupuncture therapy. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris. This exclusion also applies to biofeedback, recreational, or educational sleep therapy or other forms of self-care or non-medical self-help training and any related diagnostic testing.
6. **Before Coverage Begins / After Coverage Ends -** Services rendered or supplies provided before coverage begins, i.e., before a Member's Effective Date, or after coverage ends.
7. **Biomicroscopy -** Biomicroscopy, field charting or aniseikonic investigation.
8. **Certain Providers –** Service You get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples of non-covered Providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.
9. **Comfort and Convenience Items -** Personal comfort items such as those that are furnished primarily for Your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
10. **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.
11. **Compound Drugs** – Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, and

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.

12. **Cosmetic Services -** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how You look or are given social reasons. No benefits are available for surgery or treatments to change the texture or look of Your skin or to change the size, shape or look of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts). This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.
13. **Court-Ordered Services -** Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.
14. **Crime and Incarceration -** Injuries received while committing a crime as well as care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, unless otherwise required by law or regulation. This Exclusion does not apply if Your involvement in the crime was solely the result of a medical or mental condition, or where You were the victim of a crime, including domestic violence.
15. **Custodial Care and Rest Care -** Custodial care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain.
16. **Daily Room Charges -** Daily room charges while the Plan is paying for an Intensive care, cardiac care, or other special care unit.
17. **Dental Care -** Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
18. **Educational Services -** Educational services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, learning disorders, behavioral training, and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Plan provides for neurological disorders), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental retardation. Special education, including lessons in sign language to instruct a Member, whose ability to speak have been lost or impaired, to function without that ability, is not covered..
19. **Excessive Expenses -** Expenses in excess of the Plan's Maximum Allowed Amount.
20. **Employer or Association Medical / Dental Department -** Received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust or similar person or group.
21. **Experimental / Investigational Services -** Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in Anthem's judgment, Experimental or Investigative for the diagnosis for which the Member is being treated. An Experimental or Investigative service is not made eligible for coverage by the fact that other treatment is considered by a Member's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.

22. **Family Members -** Services rendered by a Provider who is a close relative or member of Your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.
23. **Foot Care -** Foot care (except for treatment of diabetes and when related to accidental Injury) to improve comfort or appearance, routine care of corns, calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and accidental Injury.
24. **Free Services -** Services and supplies for which You have no legal obligation to pay, or for which no charge has been made or would be made if You had no health insurance coverage.
25. **Gene Therapy -** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
26. **Government Programs -** Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Member had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
27. **Hair -** Hair transplants, hair pieces or wigs (except when necessitated by disease) wig maintenance, or Prescriptions or medications related to hair growth.
28. **Health Spa -** Expenses incurred at a health spa or similar Facility.
29. **Ineligible Hospital -** Any services rendered or supplies provided while You are confined in an Ineligible Hospital.
30. **Ineligible Provider -** Any services rendered or supplies provided while You are a patient or receive services at or from an Ineligible Provider.
31. **Infertility Services** – For artificial insemination; fertilization (such as in vitro, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), reversal of sterilization or elective procedures related to fertilization; infertility drugs and related services following the diagnosis of infertility.
32. **Inpatient Rehabilitation Programs -** Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation Facility, when the Member is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
    a. the treatment is for maintenance therapy; or
    b. the Member has no restorative potential; or
    c. the treatment is for congenital learning or neurological disability/disorder; or
    d. the treatment is for communication training, educational training or vocational training.
33. **International Services -** Non-emergency treatment of chronic illnesses received outside the United States performed without preauthorization. See the information on the Blue Cross Blue Shield Global Core® Basic International Coverage program in this Benefit Booklet for further details.
34. **Maintenance Care -** Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, Injury or condition which is resolved or stable.
35. **Marital Counseling -** Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
36. **Medicare** – For which benefits are payable under Medicare Parts A and/or B or would have been payable if You had applied for Parts A and/or B, except as listed in this Benefit Booklet or as required by Federal law, as described in the section titled “Medicare” in **General Information**.

37. **Mental Health and Substance Use Treatment -** Any Mental Health or Substance Use treatment, unless otherwise specified as covered in this Benefit Booklet.
38. **Never Events –** The Plan will not pay for errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care Facility. The Provider will be expected to absorb such costs. This Exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.
39. **Non-Approved Drugs** – Drugs not approved by the FDA.
40. **Non-Covered Services -** Any item, service, supply or care not specifically listed as a Covered Service in this Benefit Booklet.
41. **Not Medically Necessary Services -** Care, supplies, or equipment not Medically Necessary, as determined by Anthem, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet Anthem's medical policy, clinical coverage guidelines, or benefit policy guidelines.
42. **Obesity Services -** Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to Enteral feeding except when it's the sole means of nutrition. Food supplements. Any services or supplies that involve weight reduction as the main method of treatment, including medical, or counseling. Weight loss programs including but not limited to: commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. This exclusion does not apply to morbid obesity surgery when approved by the Plan.
43. **Over the Counter Drug Equivalents -** Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply. This Exclusion does not apply to over-the-counter products that the Plan must cover as a "Preventive Care" benefit under Federal law with a Prescription.
44. **Prescription Drugs -** Any prescription drugs purchased at a retail or Home Delivery Mail Service Pharmacy. (These are covered by a separate vendor).
45. **Private Duty Nursing –** For Private Duty Nursing services except when provided through the "Home Care" benefit.
46. **Private Rooms -** Private rooms are not covered by this Plant, except as specified as Covered Services.
47. **Research Screenings –** For examinations related to research screenings, unless required by law.
48. **Reversal of Elective Sterilization -** Services related to or performed in conjunction with reverse elective sterilization.
49. **Routine Examinations -** Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms illness or Injury except those which may be specifically listed as covered in this Benefit Booklet.
50. **Safe Surroundings -** Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
51. **Sclerotherapy -** Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
52. **Services Not Specified as Covered.** No Benefits are available for services that are not specifically described as Covered Services in this Benefit Booklet. This exclusion applies even if Your Physician orders the service.
53. **Sexual Dysfunction -** Medical/ surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies, including treatment for impotency (except male organic erectile

dysfunction) regardless of origin or cause. This exclusion also includes penile prostheses or Implants and vascular or artificial reconstruction, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

54. **Sexual Transformation -** Surgical care or medical treatment or study related to the modification of sex (transsexualism) and related services, or the reversal thereof.

55. **Shoes and Orthotics -** Shoe inserts, orthotics (except when prescribed by a Physician for diabetes and orthopedic shoes (except when an orthopedic shoe is joined to a brace).

56. **Smoking Cessation –** Smoking Cessation programs and treatment of nicotine addiction including gum, patches and Prescription Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products, unless otherwise required by law. Refer to '**Preventive Services'** in the '**Schedule of Benefits'** section.

57. **Spider Veins -** Treatment of telangiectatic dermal veins (spider veins) by any method.

58. **Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary -** Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to:
    a. Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards;
    b. Household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs;
    c. The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment;
    d. Water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers;
    e. Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to a Member's house or place of business and adjustments made to vehicles;
    f. Air conditioners, humidifiers, dehumidifiers, or purifiers;
    g. Rental or purchase of equipment if You are in a Facility which provides such equipment;
    h. Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications; and,
    i. Other items of equipment that Anthem determines do not meet the listed criteria.

59. 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 Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

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

61. **Therapy Services -** Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.

62. **Transplant Services** - The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
    a. Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;

b. Transportation, travel or lodging expenses for non-donor family Members;
c. Donation related services or supplies, including search, associated with organ acquisition and procurement;
d. Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered; any transplant not specifically listed as covered.
e. Any transplant not specifically listed as covered.

63. **Transportation -** Transportation provided by other than a state licensed professional ambulance service, and Ambulance Services that are not Medically Necessary. Transportation to another area for medical care is also excluded except as stated as covered under the "Ambulance Service" section. Ambulance transportation from the Hospital to the home is not covered.
64. **Travel Costs and Mileage -** For mileage costs or other travel expenses, except as authorized by Anthem, on behalf of the State.
65. **Thermograms -** Thermograms and thermography.
66. **Vein Treatment -** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
67. **Vision Care -** Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated in this Benefit Booklet. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.
68. **Vision Surgeries -** Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
69. **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.
70. **Waived Fees -** Any portion of a Provider's fee or charge which is ordinarily due from a Member but which has been waived. If a Provider routinely waives (does not require the Member to pay) an Deductible or Out-of-Pocket amount, Anthem will calculate the actual Provider fee or charge the fee or charge by the amount waived.
71. **War / Military Duty -** Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military Facilities except as required by law.
72. **Worker's Compensation -** Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. If Workers' Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.

CLAIMS PAYMENT

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

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

How to File Claims

Under normal conditions, Anthem should receive the proper claim form within 15 months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

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

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

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

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

Maximum Allowed Amount

General

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

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

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

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

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

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

Provider Network Status

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

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

Providers who have not signed any contract with Anthem and are not in any of Anthem's 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 Plan will be one of the following as determined by Anthem:

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

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is 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 Anthem or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

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

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

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

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

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

Member Cost Share

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

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

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

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or Facility, You will pay the Network cost share amounts

for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

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

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

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

Timeliness of Filing − Member Submitted Claims
To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 15 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, Anthem will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

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

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

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

Notice of Claim & Proof of Loss
After You get Covered Services, we must receive written notice of Your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless required by law.

In certain cases, You may have some extra time to file a claim. If we did not get Your claim within 90 days, but it is sent in as soon as reasonably possible and within one year after the 90-day period ends (i.e., within 15 months), You may still be able to get benefits. **However, any claims, or additional information on claims, sent in more than 15 months after you get Covered Services will be denied, unless an extension is required by Federal law.**

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 (including if You fail to enroll under Part B of the Medicare program where Medicare is the responsible payer), You will be responsible for any charge for services.

Explanation of Benefits

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

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

Inter-Plan Arrangements

Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. Blue Card® Program

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

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that

Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

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

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

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

C. Special Cases: Value-Based Programs

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

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

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

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

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

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

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

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

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

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

Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Member's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

Assignment

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, 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 also reserves the right, in its own discretion, to make payments directly to You as opposed to any Provider for Covered Service. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Employer'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 Employer'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, ERISA or any applicable Federal law.

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

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

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

Questions About Coverage or Claims

If You have questions about Your coverage, contact the State or Anthem’s Member Services Department at 1.844.891.8359. Be sure to always give Your Member Identification number.

When asking about a claim, give the following information:

- identification number;
- patient’s name and address;
- date of service and type of service received; and
- Provider name and address (Hospital or Physician).

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

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

An oral explanation of Your benefits by an Employee of Anthem or the State is not legally binding.

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

YOUR RIGHT TO APPEAL

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

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

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

The Complaint Procedure

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

Please refer to Your Identification Card for Anthem' address and telephone number.

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

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

Appeal Procedures

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

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

Internal Appeals

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

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

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

Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

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

Anthem will also accept appeals filed in writing. If You wish to file Your appeal in writing, You must mail it to:

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

or to the address provided for filing an appeal on any written notice of an adverse decision that You receive from Anthem.

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

Standard Appeals

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

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

Appeal of an Adverse Pre-service Review/Prior Authorization Decision

If the Plan's decision regarding your Pre-service Review or Prior Authorization of a health care service, device, or drug submitted electronically by your Provider is appealed, the Plan will consider the appeal:

- Within forty-eight (48) hours after the appeal is received if it's for Urgent Care Services;
- Within ten (10) calendar days after the appeal is received for all other services if it's for non Emergency or non-Urgent Care Services.

The appeal shall be between the Provider requesting the service in question and a clinical peer.

If the appeal does not resolve the disagreement, either your or your authorized representative may request an External Review as described in this section.

For purposes of this section only, Urgent Care Services means medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state;

- In the opinion of a practitioner with knowledge of the patient's medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of a Pre service Review request as outlined in the Health Care Management section of this Benefit Booklet.

This section does not apply to Emergency services.

Once a Pre-service Review or Prior Authorization is approved, it will not be retroactively denied except in cases of fraudulent or materially incorrect information, or as otherwise provided under applicable state law.

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

You may request an expedited review for:

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

Exhaustion of Internal Appeals Process

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:

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

External Review

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

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

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

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

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

"Covered person" means a subscriber, enrollee, member, or individual covered by a health benefit plan. "Covered person" does include the covered person's authorized representative with regard to an internal appeal or external review.

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

"Final adverse benefit determination" means an adverse benefit determination that is upheld at the completion of a health plan issuer's internal appeals process.

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

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

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

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

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

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

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

"Superintendent" means the superintendent of insurance.

Understanding the External Review Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.

- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

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

Binding Nature of External Review Decision
An external review decision is binding on the Plan except to the extent Anthem has other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law. A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to Anthem.

If You Have Questions About Your Rights or Need Assistance
You may contact Anthem:

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

To contact Anthem by phone please call **1.844.891.8359.**
Fax: **1-888-859-3046**
E-Mail: **Ohio.Appeals@anthem.com**

You may also contact the Ohio Department of Insurance:

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

Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

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

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

COORDINATION OF BENEFITS (COB)

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

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

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

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

COB DEFINITIONS

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

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

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

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

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

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

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

The following are non-Allowable expenses:

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

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

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

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active Employee, that is, an Employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off Employee is the Secondary Plan. The same would hold true if You are a Dependent of an active Employee and You are a Dependent of a retired or laid-off Employee. If the other

Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Subscribers with active current employment status age 65 or older and their Spouses age 65 or older; and
- Individuals with end-stage renal disease, for a limited period of time.

Your current coverage is primary and Medicare is almost always secondary (and is only primary in a few instances).

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don't accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total Allowable Expense.

SUBROGATION AND REIMBURSEMENT

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

Recovery
A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, workers’ compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how You or Your representative or any agreements characterize the money You receive as a Recovery, it shall be subject to these provisions.

Subrogation
The Plan has the right to recover payments it makes on Your behalf from any party responsible for compensating You for Your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or 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 those rights.
- In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement
If You obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on Your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on Your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan’s rights will not be reduced due to Your negligence.
- 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. You and Your legal representative acknowledge that the portion of the Recovery to which the Plan’s equitable lien applies is a Plan asset.
- Any Recovery You obtain must not be dissipated or disbursed until such time as the Plan has been 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, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan if:
  1. The amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.
- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- 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 You 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, 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 the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal Injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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 its 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.

GENERAL INFORMATION

Entire Agreement

This Benefit Booklet, the State's application, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between Anthem and the State and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to Anthem by the State, and any and all statements made to the State by Anthem, are representations and not warranties, and no such statement unless it is contained in a written application for coverage under the Plan, shall be used in defense to a claim under the Plan.

Form or Content of Benefit Booklet

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

Circumstances Beyond the Control of the Plan

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

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. The State's Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the State's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. Since Anthem administers the claims for the State's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact the Member Services at 1.844.891.8359.

Workers' Compensation

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

Other Government Programs

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

Medicare Program

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to Federal

court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and Federal law.

Except when Federal law required us to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to You shall be reimbursed by or on Your behalf to us, to the extent we have made payment for such services.

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

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

Relationship of Parties (State - Member - Claims Anthem)

Neither the State nor any Member is the agent or representative of Anthem.

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

Relationship of Parties (Anthem - Network Providers)

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

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

Community Insurance Company (OH)

The State, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the State and Community Insurance Company (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Ohio. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

Notice

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

Modifications or Changes in Coverage

The State 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 State, or by mutual agreement between Anthem and the State without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Fraud

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

Acts Beyond Reasonable Control (Force Majeure)

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

Anthem will adhere to the State's instructions and allow the State to meet all of the State's responsibilities under applicable state and federal law. It is the State's responsibility to adhere to all applicable state and federal laws and Anthem does not assume any responsibility for compliance.

Conformity with Law

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

Clerical Error

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

Policies and Procedures

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

Under the terms of the Administrative Service Agreement with The State, Anthem has the authority, in its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of Anthem's ongoing effort to find innovative ways to make available high quality and more affordable healthcare.

A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of benefits which are not provided in the State's Group Health Plan, unless otherwise agreed to by the State. Anthem reserves the right to discontinue a pilot initiative at any time without advance notice to the State.

Value-Added Programs

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

Waiver

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

Employer's Sole Discretion

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

Reservation of Discretionary Authority

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

Governmental Health Care Programs

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

Medical Policy and Technology Assessment

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.

Payment Innovation Programs

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

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

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

Care Coordination

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

Program Incentives

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

Confidentiality and Release of Information

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

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

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

WHEN COVERAGE TERMINATES

Termination of Coverage (Individual)

Membership for You and Your enrolled family members may be continued as long as You are employed by the State and meet eligibility requirements. It ceases if Your employment ends, if You no longer meet eligibility requirements, if the Plan ceases, or if You fail to make any required contribution toward the cost of Your coverage. In any case, Your coverage would end at the expiration of the period covered by Your last contribution.

Coverage of an enrolled child ceases automatically at the end of the month when the child attains the age limit shown in the Eligibility section. Coverage of an impaired child over age 26 ceases if the child is found to be no longer totally or permanently impaired.

Coverage of the Spouse of a Subscriber terminates automatically as of the date of divorce or death.

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

Continuation of Coverage (Federal Law-COBRA)

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

Qualifying events for Continuation Coverage under Federal Law (COBRA)

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

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

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

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

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

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

Notification Requirements
In the event of Your termination, lay-off, reduction in work hours or Medicare entitlement, The State must notify the COBRA Administrator within 30 days. You must notify the State within 60 days of Your divorce, legal separation or the failure of Your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights within 14 days.

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

For Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the State can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the State of that fact in writing within 30 days after the Social Security Administration's determination.)

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

When COBRA Coverage Ends

These benefits are available without proof of insurability and coverage will end on the earliest of the following:

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

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

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

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

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

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the State must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her State of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the State upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee's reinstatement of coverage.

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

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

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

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

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

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

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

For more information about Your rights under ERISA, if this plan is subject to ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S Department of Labor's Employee Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at *www.dol.gov/ebsa*.

DEFINITIONS

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

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

Authorized Service(s)
A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Anthem to be paid at the Network level. The Member **may** be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the "Claims Payment" section.

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

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

Claims Administrator
The company the State chose to administer its health benefits. Community Insurance Company was chosen to administer this Plan. Anthem 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.

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

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

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

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

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

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

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

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

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

Covered Transplant Procedure
Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by Anthem including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

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

adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible
The portion of the bill You must pay before Your medical expenses become Covered Services.

Dependent
The Spouse and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Mentally retarded or physically disabled children remain covered no matter what age. The certification form may be obtained from Anthem or The State. This proof of incapacity may be required annually by the Plan.

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

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

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

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

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

Emergency (Emergency Medical Condition) – An accidental traumatic bodily injury or other medical or behavioral health condition that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- Place the health of an individual, or the health of another person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care (Emergency Services) - A medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical or behavioral health examinations and treatment as are required to Stabilize the patient.

Employee
A person who is engaged in active employment with the State and is eligible for Plan coverage under the employment regulations of the State. The Employee is also called the Subscriber.

Employer
The State of Ohio.

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

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

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

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

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

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

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or Facilities or by other treating Physicians, other medical professionals or Facilities studying substantially the same Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

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

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

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

Group Health Plan, or Plan
An Employee Welfare Benefit Plan (as defined in Section 3(1) of ERISA, established by the State, in effect as of the Effective Date.

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

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

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

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

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

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

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

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

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

Infertile or Infertility
The condition of a presumably healthy Member who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

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

Injury
Bodily harm from a non-occupational accident.

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

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

Late Enrollees
Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan: (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan Year
The period of time beginning at 12:00 A.M. on 07/01/17, continuing through the following January, and ending on 06/30/18 at 11:59 P.M. It does not begin before a Member's Effective Date. It does not continue after a Member's coverage ends.

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

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

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

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

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

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

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

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

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

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

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

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

Telemedicine/Telehealth
The mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. 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.

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

Transplant Providers

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

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

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by Anthem nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

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

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

You and Your
Refer to the Subscriber, Member and each Covered Dependent.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in Anthem's Network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact Member Services at 1.844.891.8359 or refer to Anthem's website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need prior authorization from the Plan or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in Anthem's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Member Services at 1.844.891.8359 or refer to Anthem's website, www.anthem.com.

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

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

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

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

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

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

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

If You would like more information on WHCRA benefits, call the State.

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

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

Mental Health Parity and Addiction Equity Act

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

Special Enrollment Notice

If You are declining enrollment for yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll yourself or Your Dependents in this Plan, if You or Your Dependents lose eligibility for that other coverage (or if the State 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 State 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 Employees and Dependents may also enroll under two additional circumstances:

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

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

To request special enrollment or obtain more information, call Member Services at 1.844.891.8359 or contact the State.

PLAN ADMINISTRATION

NOTE: This section is not a part of your Benefit Booklet. Anthem is not responsible for any statements contained herein that are not set forth in the Administrative Services Agreement or the Benefit Booklet.

- **Plan Name: OHIO MED PPO**
- **Plan Sponsor: STATE OF OHIO**
  30 East Broad Street, 27th Floor
  Columbus, Ohio 43215
- **Plan Number: 001**
- **Employer I.D. Number: 31-6402047**
- **Type of Plan:** The Plan is an Employee benefit plan providing group medical benefits.
- **Plan Year Ends: 06/30/2019**
- **Type of Administration/Funding:** Medical benefits are furnished under a health care plan funded by the State on a self-funded basis with claims being administered by Anthem Insurance Companies on behalf of State Of Ohio.
- **Plan Administrator and Named Fiduciary: STATE OF OHIO**
- **Agent for Service of Legal Process. STATE OF OHIO**

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

IT'S IMPORTANT WE TREAT YOU FAIRLY

That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on Your Identification Card for help (TTY/TDD: 711). If You think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, You can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or You can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

GET HELP IN YOUR LANGUAGE

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

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

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

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

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

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

Bassa
Ǹ ɓéɖé dyí-ɓèɖèìn-ɖèɔ̀ ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ðá mɛ́ɓà jè gbo-gmɔ̀ Kpòɛ̀ nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̀oi kɔ̃ɛ ɓɛ́ m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

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

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

Dinka

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

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

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

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

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

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

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

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

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

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

Indonesian

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

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

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

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

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

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

Ohio Med PPO Plan
Package Code 001