GROUP NAME:	**THE RESEARCH FOUNDATION FOR THE STATE UNIVERSITY OF NEW YORK**
GROUP NUMBER:	**L1217415AM, 15AC, 19AM, 19AC, 39AM, 39AC, 17BM, 17BC, 32AM, 32AC, 17AM, 17AC, 17SM, 17SC**
EFFECTIVE DATE:	**01-01-2025**

This is Your

Anthem PPO Copay Deductible and Coinsurance

BENEFIT BOOKLET

Issued by: Anthem HealthChoice Assurance, Inc.

This Benefit Booklet ("Booklet") explains the benefits available to You under the health care plan (the "Plan") offered by Your Employer.

You should read this Booklet carefully to get to know the Plan's main provisions and keep it handy for reference. A thorough understanding of Your coverage will allow You to use Your benefits wisely. If You have any questions about the benefits shown in this Booklet, please call the Customer Service number on the back of Your Identification Card.

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

If You need Spanish-language assistance to understand this document, You may request it at no additional cost by calling Customer Service at the number on the back of Your Identification Card.

Important

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

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

NY 2025

This Booklet explains the benefits available to You under the health care plan (the “Plan”) offered by Your Employer.

You should read this Booklet carefully to get to know the Plan’s main provisions and keep it handy for reference. A thorough understanding of Your coverage will allow You to use Your benefits wisely. If You have any questions about the benefits shown in this Booklet, please call the Customer Service number on the back of Your Identification Card.

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

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

Many words used in the Booklet have special meanings (e.g., Employer, Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Booklet You will also see references to “We”, “Us”, “Our”, “You”, and “Your”. The words “We”, “Us”, and “Our” mean the Claims Administrator. The words “You” and “Your” mean the Member, Subscriber and each covered Dependent.

If You have any questions about Your Plan, please be sure to call Customer Service at the number on the back of Your Identification Card. Also be sure to check the Claims Administrator’s website, *www.anthembluecross.com* for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips.

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

This Booklet offers You the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in Our PPO/EPO Network and Participating Pharmacies in Our Base with R90 Network. You should always consider receiving health care services first through the in-network benefits portion of this Booklet.

2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Booklet provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider’s charge.

TABLE OF CONTENTS

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

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

Surprise Billing Claims

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

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

NO SURPRISES ACT REQUIREMENTS

Emergency Services

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

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

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

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

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

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

Facility will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services.

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

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

Out-of-Network Air Ambulance Services

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

How Cost-Shares Are Calculated

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

Appeals

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

PROVIDER DIRECTORIES

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

TRANSPARENCY REQUIREMENTS

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

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

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

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

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

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

NOTICE REGARDING RETIREE-ONLY PLANS

If this Plan is issued as part of a retiree-only plan, as defined by ERISA §732(a) and IRC §9831(a)(2), the provisions of the Consolidated Appropriations Act of 2021 will not apply, including the provisions regarding the No Surprises Act. In a retiree-only plan, Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount. Please contact your Employer or former Employer if you are unsure whether your plan is a retiree-only plan.

FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

CHOICE OF PRIMARY CARE PHYSICIAN

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

ACCESS TO OBSTETRICAL AND GYNECOLOGICAL (OBGYN) CARE

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

ADDITIONAL FEDERAL NOTICES

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT

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

STATEMENT OF RIGHTS UNDER THE WOMEN'S CANCER RIGHTS ACT OF 1998

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

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

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

COVERAGE FOR A CHILD DUE TO A QUALIFIED MEDICAL SUPPORT ORDER ("QMCSO")

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

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

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

SPECIAL ENROLLMENT PERIODS

You, Your Spouse or Child, can also enroll for coverage within 60 days of the loss of coverage in another Employer health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other Employer health plan due to:

- Termination of employment;
- Termination of the other Employer health plan;
- Death of the Spouse;
- Legal separation, divorce or annulment;
- Reduction of hours of employment;
- Employer contributions toward the Employer health plan were terminated; or
- A Child no longer qualifies for coverage as a Child under the other Employer health plan.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage.

We must receive notice within 60 days of the loss of coverage. The effective date of Your coverage will be the date indicated on the application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

- You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan; or
- You or Your Spouse or Child becomes eligible for Medicaid or a state child health plan.

We must receive notice within 60 days of one of these events. The effective date of Your coverage will be the date indicated on the application.

STATEMENT OF ERISA RIGHTS

Please note: This section applies to employer sponsored plans other than Church employer groups and government groups. If You have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Employer).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Employer under this Plan, to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for You and other employees, ERISA imposes duties on the people responsible for the operation of Your employee benefit plan. The people who operate Your plan are called plan fiduciaries. They must handle Your plan prudently and in the best interest of You and other plan participants and beneficiaries. No one, including Your Employer, Your union, or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a welfare benefit or exercising Your right under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have Your claims reviewed and reconsidered.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan Administrator and do not receive them within 30 days, You may file suit in a

federal court. In such case, the court may require the Plan Administrator to provide You the materials and pay You up to $110 a day until You receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order You to pay these expenses, for example, if it finds Your claim is frivolous. If You have any questions about Your plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

SCHEDULE OF BENEFITS

Dependent Child(ren) age limit:	Coverage lasts until the end of the month in which the Child turns 26.
Provider Network applicable to this Plan	PPO/EPO Network
Plan Year	A calendar year ending on December 31 of each year.

COST-SHARING	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider** **Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $500 $1,250	 $1,500 $3,750	
Out-of-Pocket Limit • Individual • Family	 $1,500 $3,750	 $5,500 $13,750	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$30 Copayment per visit not subject to Deductible in Office $30 Copayment per visit not subject to Deductible by Telehealth	40% Coinsurance after Deductible in Office 40% Coinsurance after Deductible by Telehealth	See benefit for description
Specialist Office Visits (or Home Visits)	$30 Copayment per visit not subject to Deductible in Office $30 Copayment per visit not subject to Deductible by Telehealth	40% Coinsurance after Deductible in Office 40% Coinsurance after Deductible by Telehealth	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description

• Adult Annual Physical Examinations*	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description
• Adult Immunizations*	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description
• Routine Gynecological Services/Well Woman Exams*	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description
• Sterilization Procedures for Women*	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description
• Vasectomy	Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)	40% Coinsurance after Deductible	See benefit for description
• Bone Density Testing*	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description
• Prostate Cancer Screening	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description
• Colon Cancer Screening*	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description
• All other preventive services required by USPSTF and HRSA.	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.	Use Cost-Sharing for appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	

EMERGENCY CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance)	10% Coinsurance after Deductible	Covered as in-network	See benefit for description
Non-Emergency Ambulance Services (Ground and Air Ambulance)	10% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Emergency Department Copayment waived if admitted to Hospital	$50 Copayment per visit not subject to Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	Covered as in-network	See benefit for description
Urgent Care Center	$30 Copayment per visit not subject to Deductible	Covered as in-network	See benefit for description Out-of-network Covered same as in-network for an Emergency Condition.
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description Unlimited visits per Plan Year
Advanced Imaging Services • Performed in an Office Setting • Performed in a Freestanding Radiology Facility	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

• Performed as Outpatient Hospital Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
Allergy Testing and Treatment Testing • Performed in a PCP Office • Performed in a Specialist Office Treatment • Performed in a PCP Office • Performed in a Specialist Office	 10% Coinsurance after Deductible 10% Coinsurance after Deductible No Copayment, Deductible, or Coinsurance No Copayment, Deductible, or Coinsurance	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Cardiac Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 10% Coinsurance after Deductible 10% Coinsurance after Deductible Included as part of Inpatient Hospital service Cost-Sharing	 40% Coinsurance after Deductible 40% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing	Unlimited visits per Plan Year
Chemotherapy and Immunotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

Chiropractic Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services • Performed at Home	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Home Health Care	10% Coinsurance not subject to Deductible	40% Coinsurance not subject to Deductible	200 visits per Plan Year
Infertility Services • Artificial Insemination • In Vitro fertilization, GIFT, ZIFT	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Use Cost-Sharing for appropriate Service Use Cost-Sharing for appropriate Service	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Use Cost-Sharing for appropriate service Use Cost-Sharing for appropriate service	See benefit for description 3 cycles lifetime maximum

Infusion Therapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance not subject to Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance not subject to Deductible	See benefit for description Home Infusion provided by Home Health Agency counts toward Home Health Care visit limits
Inpatient Medical Visits	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy • Abortion Services	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description
Laboratory Procedures • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Maternity and Newborn Care • Prenatal Care ○ Prenatal Care provided in accordance with the comprehensive guidelines	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	See benefit for description

supported by USPSTF and HRSA			
○ Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
• Global fee for the Physician and Midwife Services for Delivery and for Postnatal Care	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Inpatient Hospital Services and Birthing Center	Included as part of Inpatient Hospital service Cost-Sharing	40% Coinsurance after Deductible (Birthing Center not Covered)	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Breastfeeding Support, Counseling and Supplies, including Breast Pumps	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible	One (1) breast pump per pregnancy for the duration of breast feeding
Outpatient Hospital Surgery Facility Charge	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Preadmission Testing	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities			See benefit for description
• Performed in a PCP Office	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in a Specialist Office	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Performed in Outpatient Facilities	10% Coinsurance after Deductible	40% Coinsurance after Deductible	

Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	10% Coinsurance after Deductible 10% Coinsurance after Deductible Included as a part of inpatient Hospital services Cost-Sharing	40% Coinsurance after Deductible 40% Coinsurance after Deductible Included as a part of inpatient Hospital services Cost-Sharing	See benefit for description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Physical Therapy • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	90 visits per Plan Year

Occupational and Speech Therapies • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	60 combined visits per Plan Year
Retail Health Clinic Care	$30 Copayment per visit not subject to Deductible	40% Coinsurance after Deductible	See benefit for description
Second Opinions on the Diagnosis of Cancer, Surgery and Other • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $30 Copayment per visit not subject to Deductible $30 Copayment per visit not subject to Deductible 10% Coinsurance after Deductible	Second opinions on diagnosis of cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when authorization is obtained 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Surgery Performed in a PCP Office	 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

• Surgery Performed in a Specialist Office	10% Coinsurance after Deductible	40% Coinsurance after Deductible	
Telemedicine Program • Virtual Medical Visits including Primary Care from Our preferred online Virtual Care-Only Providers • Virtual Medical Visits including Primary Care from all other Virtual Care-Only Providers • Virtual Medical Visits including Specialty Care from Virtual Care-Only Providers	No Copayment, Deductible, or Coinsurance No Copayment, Deductible, or Coinsurance $30 Copayment per visit not subject to Deductible	Refer to the "Office Visits" section	See benefit for description
Vision Therapy • Performed in a PCP Office • Performed in a Specialist Office	$30 Copayment per visit not subject to Deductible $30 Copayment per visit not subject to Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment and Supplies (30-day supply) – Performed in an Office Setting or by a third-party supplier – Performed as Outpatient Hospital Services	No Copayment, Deductible, or Coinsurance No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

• Diabetic Insulin (30-day supply) • Oral anti-diabetic agents and injectable anti-diabetic agents (30-day supply) • Diabetic Education	No Copayment, Deductible, or Coinsurance No Copayment, Deductible, or Coinsurance No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	
Durable Medical Equipment and Braces – Performed in an Office Setting or by a third-party supplier – Performed as Outpatient Hospital Services	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 Not Covered Not Covered	See benefit for description
External Hearing Aid • Prescription Hearing Aids • Over-the-Counter Hearing Aids	 No Copayment, Deductible, or Coinsurance No Copayment, Deductible, or Coinsurance	 Covered same as In-Network (Member is responsible for charges above the Maximum Allowed Amount) Covered same as In-Network (Member is responsible for charges above the Maximum Allowed Amount)	One (1) hearing aid per ear every 3 years combined; fitting and maintenance included, batteries and supplies included
Cochlear Implants	10% Coinsurance after Deductible	Not Covered	One (1) per ear per time Covered

Hospice Care • Inpatient • Outpatient	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 Not Covered Not Covered	365 days per Plan Year 5 visits for family bereavement counseling
Medical Supplies • Performed in an Office Setting or by a third-party supplier • Performed as Outpatient Hospital Services	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 Covered same as In-network 40% Coinsurance after Deductible	See benefit for description
Orthotics	10% Coinsurance after Deductible	Not Covered	See benefit for description
Prosthetic Devices • External • Internal	 10% Coinsurance after Deductible 10% Coinsurance after Deductible	 Not Covered Not Covered	See benefit for description
Wig	10% Coinsurance after Deductible	Not Covered	See benefit for description
Lenses and/or Glasses after cataract surgery 2 per lifetime	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Autologous Blood Banking Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description

Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Observation Stay	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	10% Coinsurance after Deductible	Not Covered	120 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	60 days per Plan Year
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital or Residential Facility	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services	 $30 Copayment per visit not subject to Deductible in Office $30 Copayment per visit not subject to Deductible by Telehealth No Copayment, Deductible, or Coinsurance in Office No Copayment, Deductible, or Coinsurance by Telehealth	 40% Coinsurance after Deductible in Office 40% Coinsurance after Deductible by Telehealth 40% Coinsurance after Deductible in Office 40% Coinsurance after Deductible by Telehealth	See benefit for description

ABA Treatment for Autism Spectrum Disorder • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $30 Copayment per visit not subject to Deductible in Office $30 Copayment per visit not subject to Deductible by Telehealth $30 Copayment per visit not subject to Deductible in Office $30 Copayment per visit not subject to Deductible by Telehealth No Copayment, Deductible, or Coinsurance in Office No Copayment, Deductible, or Coinsurance by Telehealth	 40% Coinsurance after Deductible in Office 40% Coinsurance after Deductible by Telehealth 40% Coinsurance after Deductible in Office 40% Coinsurance after Deductible by Telehealth 40% Coinsurance after Deductible in Office 40% Coinsurance after Deductible by Telehealth	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	$30 Copayment per visit not subject to Deductible	Not Covered	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	10% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits	 $30 Copayment per visit not subject to Deductible in Office $30 Copayment per visit not subject to Deductible by Telehealth	 40% Coinsurance after Deductible in Office 40% Coinsurance after Deductible by Telehealth	Unlimited visits per Plan Year Up to 20 visits per Plan Year may be used for family counseling

• Opioid Treatment Programs	No Copayment, Deductible, or Coinsurance in Office No Copayment, Deductible, or Coinsurance by Telehealth	40% Coinsurance after Deductible in Office 40% Coinsurance after Deductible by Telehealth	
• All Other Outpatient Services	No Copayment, Deductible, or Coinsurance in Office No Copayment, Deductible, or Coinsurance by Telehealth	40% Coinsurance after Deductible in Office 40% Coinsurance after Deductible by Telehealth	
WELLNESS BENEFITS	**Participating Provider** **Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Annual Reimbursement for Gym Membership	Up to $400		See benefit for description

DEFINITIONS

Defined terms will appear capitalized throughout this Booklet.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Administrative Services Agreement: The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Booklet for a description of how the Allowed Amount is calculated. If Your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Booklet.

Claims Administrator: The company the Employer chose to administer its health benefits. Anthem Blue Cross was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Booklet.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;

- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

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

Employer: An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with the Claims Administrator to administer this Plan.

Exclusions: Health care services that We do not pay for or Cover.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitation Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Plan.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to New York Public Health Law Article 40 or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider. The amount can vary by the type of Covered Service.

In-Network Copayment: A fixed amount You pay directly to a Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

In-Network Cost-Sharing: Amounts You must pay to a Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers. This limit never includes Copayments, Prescription Drug Cost Shares, Your Premium or services We do not Cover.

Medically Necessary: See the How Your Coverage Works section of this Booklet for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Fees have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Network: The Providers We have contracted with to provide health care services to You.

Non-Participating Provider: A Provider who doesn't have a contract with Us or another Blue Cross and/or Blue Shield plan to provide health care services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Cost-Sharing: Amounts You must pay to a Non-Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Fee, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us or another Blue Cross and/or Blue Shield plan to provide health care services to You. A list of Participating Providers and their locations is available on Our website at *www.anthembluecross.com* or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

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

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

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

Plan Year: The Plan Year can be either the 12-month period beginning on the effective date of the Plan or any anniversary date thereafter, during which the Plan is in effect or a calendar year ending on December 31 of each year. If Your coverage ends before the end of the year, then Your Plan Year also ends. The Schedule of Benefits section of this Booklet shows if Your Plan Year is a 12-month period or a calendar year.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Preauthorization section of this Booklet.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a

prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating nurse practitioner, physician assistant or Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Booklet that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Booklet or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Booklet that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York in which We provide coverage. Our Service Area consists of the following counties in eastern New York State: Albany, Bronx, Clinton, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Kings, Montgomery, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington and Westchester.

Skilled Nursing Facility: An institution or a distinct part of an institution that is currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Subscriber: The person to whom this Booklet is issued.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: Anthem HealthChoice Assurance, Inc. and anyone to whom We legally delegate performance, on Our behalf, under this Plan.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

HOW YOUR COVERAGE WORKS

A. Your Coverage Under this Plan. Your Employer has purchased a health insurance Plan from Us. We will provide the benefits described in this Booklet to covered Members of the Employer, that is, to employees of the Employer and their covered Dependents.

B. Covered Services. You will receive Covered Services under the terms and conditions of this Plan only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider for in-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Booklet; and
- Received while Your Plan is in force.

C. Participating Providers. To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request,
- Call the number on Your ID card; or,
- Visit Our website at *www.anthembluecross.com*.

The Provider directory will give You the following information about Our Participating Providers:

- Name address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

You are only responsible for any In-Network Cost-Sharing that would apply to the Covered Services if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:

- The Provider is listed as a Participating Provider in Our online Provider directory;
- Our paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;
- We give You written notice that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider; or
- We do not provide You with a written notice within one (1) business day of Your telephone request for network status information.

In these situations, if a Provider bills You for more than Your In-Network Cost-Sharing and You pay the bill, You are entitled to a refund from the Provider, plus interest.

D. The Role of Primary Care Physicians. This Plan does not have a gatekeeper, usually known as a Primary Care Physician ("PCP"). You do not need a Referral from a PCP before receiving Specialist care.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics, and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

You may need to request Preauthorization before You receive certain services. See the Preauthorization section of this Booklet for the services that require Preauthorization.

E. Access to Providers and Changing Providers. Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is

accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are an Anthem Member in the network applicable to Your plan as indicated in the Schedule of Benefits section of this Booklet, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

F. Out-of-Network Services. We Cover the services of Non-Participating Providers. See the Schedule of Benefits section of this Booklet for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

G. Services Subject to Preauthorization. Our Preauthorization is required before You receive certain Covered Services. You are responsible for requesting Preauthorization for the in-network and out-of-network services listed below:

- All inpatient admissions, including maternity admissions but not including emergency admissions or services provided in a neonatal intensive care unit of a Hospital;
- Inpatient Mental Health Care, Substance Use Services;
- Mental Health and Substance Use Intensive Outpatient Program Services;
- Mental Health and Substance Use Partial Hospitalization Program Services;
- Transcranial Magnetic Stimulation (TMS);
- Skilled Nursing Facility;
- Advanced Infertility Services;
- Outpatient/Ambulatory Surgical Treatments;
- Chiropractic Care (after the 5th visit);
- Physical*, Occupational*, Vision and Speech Therapy;
- Diagnostic Radiology Services;
- Therapeutic Radiology Services;
- Air Ambulance;
- MRI, MRA;
- PET, CAT, Nuclear Technology services;
- Durable Medical Equipment*;
- Prosthetics* and Orthotics*;
- Assistive Communication Devices;
- Genetic Testing;
- Interventional Spine and Joint Pain Management Procedures.

*Preauthorization not required when services obtained out-of-network.

H. Preauthorization/Notification Procedure. If You seek coverage for services that require Preauthorization or notification, You or Your Provider must call Us at the number on Your ID card.

You or Your Provider must contact Us to request Preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when Your Provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a Hospital or in an Ambulatory Surgical Center. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.

- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if Your Hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-Emergency Condition.

You must contact Us to provide notification as follows:

- As soon as reasonably possible when air ambulance services are rendered for an Emergency Condition.
- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

I. Failure to Seek Preauthorization or Provide Notification. If You fail to seek Our Preauthorization or provide notification for benefits subject to this section, We will pay only 50% of the amount We would otherwise have paid for the care, up to the maximum penalty amount of $500, whichever results in a greater benefit for You. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization or provide notification. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service. The penalty listed above will not apply to Medically Necessary inpatient Facility services from a BlueCard Provider.

J. Medical Management. The benefits available to You under this Plan are subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

K. Medical Necessity. We Cover benefits described in this Booklet as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, “service”) is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment; and
- The opinion of Health Care Professionals in the generally-recognized health specialty involved.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;

- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and External Review sections of this Booklet for Your right to an internal appeal and external review of Our determination that a service is not Medically Necessary.

L. Delivery of Covered Services Using Telehealth. If Your Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Booklet that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies, including telephone or video using smart phones or other devices, by a Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

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

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and teamwork with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Plan. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

N. Important Telephone Numbers and Addresses.

- **CLAIMS**
  Refer to the address on Your ID card

- **COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**
  Call the number on Your ID card

- **ASSIGNMENT OF BENEFITS FORM**
  Refer to the address on Your ID card

(Submit assignment of benefits forms for surprise bills to this address.

- **MEDICAL EMERGENCIES AND URGENT CARE**
  Call the number on Your ID card

- **MEMBER SERVICES**
  Call the number on Your ID card
  Member Services Representatives are available Monday – Friday 8:30 a.m. – 5:00 p.m. E.S.T.

- **PREAUTHORIZATION**
  Call the number on Your ID card

- **OUR WEBSITE**
  www.anthembluecross.com

ACCESS TO CARE AND TRANSITIONAL CARE

A. Authorization to a Non-Participating Provider. If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve an authorization to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the authorization to a specific Non-Participating Provider. Approvals of authorizations to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the authorization, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your Participating Provider, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing. In the event an authorization is not approved, any services rendered by a Non-Participating Provider will be Covered as an out-of-network benefit if available.

B. When Your Provider Leaves the Network. If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also provide Us necessary medical information related to Your care and adhere to Our policies and procedures, including those for assuring quality of care and obtaining Preauthorization, authorizations, and a treatment plan approved by Us. You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

C. New Members In a Course of Treatment. If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Plan becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Plan. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Plan becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care and obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing.

COST-SHARING EXPENSES AND ALLOWED AMOUNT

A. Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Booklet for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Plan. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Plan collectively total the family Deductible amount in the Schedule of Benefits section of this Booklet in a Plan Year, no further Deductible will be required for any person covered under this Plan for that Plan Year.

You have a separate In-Network and Out-of-Network Deductible. Amounts You pay for out-of-network services apply toward Your In-Network Deductible. Amounts You pay for in-network services do not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**

The Deductible runs from January 1 to December 31 of each calendar year.

B. Copayments. Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Booklet for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance. Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Booklet.

You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.

D. Out-of-Pocket Limit. When You have met Your Out-of-Pocket Limit in payment of Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Booklet, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits section of this Booklet, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Plan have collectively met the family Out-of-Pocket Limit in payment of Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Booklet, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family.

Cost-Sharing for out-of-network services, except for Emergency Services, does not apply toward Your In-Network Out-of-Pocket Limit, and Cost-Sharing for in-network services does not apply towards Your Out-of-Network Out-of-Pocket Limit. The Preauthorization penalty described in the How Your Coverage Works section of this Booklet does not apply toward Your In-Network Out-of-Pocket Limit.

E. Your Additional Payments for Out-of-Network Benefits. When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this Booklet, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one (1) inclusive payment in that case rather than a separate payment for each billed code. Another example of when We will apply the payment rules to a claim is when You have surgery that involves two (2) surgeons acting as "co-surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If We receive a claim that does not have the correct modifier, We will change it and make the appropriate payment. Additionally, another example of when We will apply a payment rule to a claim is when You receive services from a Health Care Professional who is not a Physician, such as a physician's assistant. Under the payment rule, the Allowed Amount for a physician's assistant or other Health Care Professional who is not a Physician will be less than the Allowed Amount for a Physician.

F. Allowed Amount. "Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Plan, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider, or the amount approved by another Host Plan, or the Participating Provider's charge, if less.

The Allowed Amount for Non-Participating Providers in Our Service Area will be determined as follows:

1. **Facilities.** For Facilities, the Allowed Amount will be the average amounts paid by Us for comparable services to Our Participating Hospitals/Facilities in the same county. If there are no like kind Participating Hospitals and/or Facilities in the same county, then the average of amounts paid by Us for comparable services in like kind Participating Hospitals and/or Facilities in the contiguous county or counties.

2. **All Other Providers.** For all other Providers, the Allowed Amount applicable to Your Plan is 395% of the Centers for Medicare and Medicaid Services Provider fee schedule, as applicable to the Provider type, unadjusted for geographic locality.

See the Inter-Plan Programs section of the Cost-Sharing Expenses and Allowed Amount section of this Booklet for a description of how We determine the Allowed Amount for Non-Participating Providers outside Our Service Area.

Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card or visit Our website at *www.anthembluecross.com* for information on Your financial responsibility when You receive services from a Non-Participating Provider.

We reserve the right to negotiate a lower rate with Non-Participating Providers or to pay another Host Plan's rate, if lower. If the Provider participates in a network for an equivalent product offered by an affiliated insurer or HMO in another state, the rate the Provider has agreed to accept from the

other insurer or HMO will apply. Medicare based rates referenced in and applied under this section shall be updated no less than annually.

Our payments to Participating Providers may include financial incentives to help improve the quality of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to You. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

See the Emergency Services and Urgent Care section of this Booklet for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Booklet for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

G. Inter-Plan Programs

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

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

   Inter-Plan Arrangements Eligibility – Claim Types. Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that You obtain from a pharmacy and most dental or vision benefits.

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

   When You receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard® Program, the amount You pay is calculated based on the lower of:
   - The billed charges for Covered Services; or
   - The negotiated price that the Host Blue makes available to Us.

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

   Estimated pricing and average pricing, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will

not affect the price We used for Your claim because they will not be applied after a claim has already been paid.

3. **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 2. BlueCard® Program) made available to Anthem by the Host Blue.

4. **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 Plan 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.

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

6. **Non-Participating Providers Outside Our Service Area.**

   a. **Allowed Amounts and Member Liability Calculation.** When Covered Services are provided outside of Anthem's Service Area by Non-Participating Providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

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

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

   When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven (7)

days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177.

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

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 claim 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.

WHO IS COVERED

A. Who is Covered Under this Plan. You, the Subscriber to whom this Booklet is issued, are covered under this Plan. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage. We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.
2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.
3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
4. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Plan. If You selected parent and child/children or family coverage, Children covered under this Plan include Your natural Children, legally adopted Children, stepchildren, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the age set forth in the Schedule of Benefits section of this Booklet. Foster Children and grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability (as defined in the New York Mental Hygiene Law), or physical disability and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child qualifies and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Plan at any time.

D. When Coverage Begins. Coverage under this Plan will begin as follows:

1. If You, the Subscriber elect coverage before becoming eligible, or within 60 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Employer. Employers cannot impose waiting periods that exceed 90 days.

2. If You, the Subscriber do not elect coverage upon becoming eligible or within 60 days of becoming eligible for other than a special enrollment period, You must wait until the Employer's next open enrollment period to enroll, except as provided below.

3. If You, the Subscriber, marry while covered, and We receive notice of such marriage within 60 days thereafter, coverage for Your Spouse and Child starts on the date of marriage. If We do not receive notice within 60 days of the marriage, You must wait until the Employer's next open enrollment period to add Your Spouse or Child.

4. If You, the Subscriber, have a newborn or adopted newborn Child, and We receive notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth;

otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Fee within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice and the Fee payment.

E. Special Enrollment Periods. You, Your Spouse or Child, can also enroll for coverage within 60 days of the loss of coverage in another Employer health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other Employer health plan due to:

1. Termination of employment;
2. Termination of the other Employer health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the Employer health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other Employer health plan.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice within 60 days of one of these events. The effective date of Your coverage will be the date indicated on the application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

a. You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan; or
b. You or Your Spouse or Child becomes eligible for Medicaid or a state child health plan.

We must receive notice within 60 days of one of these events. The effective date of Your coverage will be the date indicated on the application.

F. Domestic Partner Coverage. This Booklet covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Booklet also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by:
   a. An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
      - The partners are both 18 years of age or older and are mentally competent to

consent to contract;
- The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
- The partners have been living together on a continuous basis prior to the date of the application; and
- Neither individual has been registered as a member of another domestic partnership within the last six (6) months;

b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
    - A joint bank account;
    - A joint credit card or charge card;
    - Joint obligation on a loan;
    - Status as an authorized signatory on the partner's bank account, credit card or charge card;
    - Joint ownership of holdings or investments;
    - Joint ownership of residence;
    - Joint ownership of real estate other than residence;
    - Listing of both partners as tenants on the lease of the shared residence;
    - Shared rental payments of residence (need not be shared 50/50);
    - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
    - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
    - Shared household budget for purposes of receiving government benefits;
    - Status of one (1) as representative payee for the other's government benefits;
    - Joint ownership of major items of personal property (e.g., appliances, furniture);
    - Joint ownership of a motor vehicle;
    - Joint responsibility for child care (e.g., school documents, guardianship);
    - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
    - Execution of wills naming each other as executor and/or beneficiary;
    - Designation as beneficiary under the other's life insurance policy;
    - Designation as beneficiary under the other's retirement benefits account;
    - Mutual grant of durable power of attorney;
    - Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
    - Affidavit by creditor or other individual able to testify to partners' financial interdependence; or
    - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

PREVENTIVE CARE

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

Preventive Care. We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your ID card or visit Our website at *www.anthembluecross.com* for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. Well-Baby and Well-Child Care. We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Cost-Sharing when provided by a Participating Provider.

B. Adult Annual Physical Examinations. We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening and diabetes screening. A complete list of the Covered preventive Services is available on Our website at *www.anthembluecross.com*, or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

C. Adult Immunizations. We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Cost-Sharing when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. Well-Woman Examinations. We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of

the Covered preventive Services is available on Our website at www.anthembluecross.com, or will be mailed to You upon request.

This benefit is not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above and when provided by a Participating Provider.

E. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39;
- Upon the recommendation of the Member's Provider, an annual screening mammogram for Members age 35 through 39 if Medically Necessary; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Cost-Sharing when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Cost-Sharing when provided by a Participating Provider.

F. Family Planning and Reproductive Health Services We Cover family planning services which consist of FDA-approved, cleared, or granted contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of this Booklet; patient education and counseling on use of contraceptives and related topics ; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Cost-Sharing when provided by a Participating Provider.

We also Cover vasectomies subject to Cost-Sharing.

We do not Cover services related to the reversal of elective sterilizations.

G. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the "Prescription Drug Coverage" section of this Booklet. Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

This benefit is not subject to Cost-Sharing when provided by a Participating Provider and in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may not include all of the above services such as drugs and devices.

H. Prostate Cancer Screening. We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Cost-Sharing when provided by a Participating Provider.

I. Colon Cancer Screening. We Cover colon cancer screening for Members age 45 through 75, including all colon cancer examinations or laboratory tests in accordance with the USPSTF and any additional screenings recommended by the American Cancer Society Guidelines for average risk individuals. This benefit includes an initial colonoscopy or other medical test for colon cancer screening and a follow-up colonoscopy performed because of a positive result from a non-colonoscopy preventive screening test.

This benefit is not subject to Cost-Sharing when provided in accordance with the recommendations of the USPSTF and when provided by a Participating Provider but may be subject to Cost-Sharing for additional screenings provided in accordance with the American Cancer Society Guidelines.

AMBULANCE AND PRE-HOSPITAL EMERGENCY MEDICAL SERVICES

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. **Pre-Hospital Emergency Medical Services.** We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

   "Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:
   - Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
   - Serious impairment to such person's bodily functions;
   - Serious dysfunction of any bodily organ or part of such person; or
   - Serious disfigurement of such person.

An ambulance service licensed under New York Public Health Law Article 30 must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible, or Coinsurance.

In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the lesser of the FAIR Health rate at the 80th percentile calculated using the place of pickup or the Provider's billed charges.

2. **Emergency Ambulance Transportation.** In addition to Pre-Hospital Emergency Medical Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground or water ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

In the absence of negotiated rates, We will pay a Non-Participating Provider licensed under New York Public Health Law Article 30 the usual and customary charge for emergency ambulance transportation, which shall not be excessive or unreasonable. The usual and customary charge for emergency ambulance transportation is the lesser of the FAIR Health rate at the 80th percentile calculated using the place of pickup or the Provider's billed charges.

We will Pay a Non-Participating Provider that is not licensed under New York Public Health Law Article 30 an amount We have determined is reasonable for the emergency ambulance transportation. However, the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

B. Non-Emergency Ground Ambulance Transportation. We Cover non-emergency ground ambulance transportation by a licensed ambulance service between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Air Ambulance Services

1. Emergency Air Ambulance Services. We Cover emergency air ambulance transportation worldwide by a licensed ambulance service to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency air ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

2. Non-Emergency Air Ambulance Services. We Cover non-emergency air ambulance transportation by a licensed ambulance service between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost effective Acute care Facility; or
- From an Acute Care Facility to a sub-Acute setting.

3. Payments for Air Ambulance Services. We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the air ambulance service.

We will pay a Non-Participating Provider an amount We have determined is reasonable for the air ambulance service. However, the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity (IDRE), We will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any In-Network Cost-Sharing for air ambulance services. The Non-Participating Provider may only bill You for Your In-Network Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Cost-Sharing, You should contact Us

D. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

EMERGENCY SERVICES AND URGENT CARE

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

A. Emergency Services. We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an "**Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**.

   We do not Cover follow-up care or routine care provided in a Hospital emergency department.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital: You or someone on Your behalf must notify Us at the number on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

   We Cover inpatient Hospital services following Emergency Department Care at a non-participating Hospital at the In-Network Cost-Sharing.

If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer.

3. **Payments Relating to Emergency Services.** We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the Emergency Services.

   We will pay a Non-Participating Provider an amount We have determined is reasonable for the Emergency Service. However, the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

   You are responsible for any Cost-Sharing.

B. Urgent Care. Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. **Urgent Care is Covered in or out of Our Service Area.**

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to, or after Your visit.

2. **Out-of-Network.** We Cover Urgent Care from non-participating Urgent Care Center or Physician.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

OUTPATIENT AND PROFESSIONAL SERVICES

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

A. Acupuncture. We Cover acupuncture services rendered by a Health Care Professional licensed to provide such services for up to the number of visits on the Schedule of Benefits section of this Booklet.

B. Advanced Imaging Services. We Cover PET scans, MRI, nuclear medicine, and CAT scans.

C. Allergy Testing and Treatment. We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

D. Ambulatory Surgical Center Services. We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

E. Chemotherapy and Immunotherapy. We Cover chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Booklet.

F. Chiropractic Services. We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Booklet.

G. Clinical Trials. We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Review sections of this Booklet.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under the Plan for non-investigational treatments provided in the clinical trial.

An "approved clinical trial" means a phase I, II, III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

H. Dialysis. We Cover dialysis treatments of an Acute or chronic kidney ailment.

I. Habilitation Services. We Cover Habilitation Services consisting of physical therapy, speech therapy

and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office. Habilitation Services are limited to the number of visits indicated on the Schedule of Benefits section of this Booklet.

J. Home Health Care. We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility.

Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational, or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility and
- Private duty nursing.

Home Health Care is limited to the number of visits on the Schedule of Benefits section of this Booklet. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation Services or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation Services or Habilitation Services benefits.

K. Infertility Treatment. We Cover services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

1. **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.

   Basic infertility services include:

   - Initial evaluation;
   - Semen analysis;
   - Laboratory evaluation;
   - Evaluation of ovulatory function;
   - Postcoital test;
   - Endometrial biopsy;
   - Pelvic ultrasound;
   - Hysterosalpingogram;
   - Sono-hystogram;
   - Testis biopsy;
   - Blood tests; and
   - Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be Covered if the tests are determined to be Medically Necessary.

2. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

   Comprehensive infertility services include:
   - Ovulation induction and monitoring;
   - Pelvic ultrasound;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **Advanced Infertility Services**. We Cover the following advanced infertility services:
   - Three (3) cycles per lifetime of in vitro fertilization;
   - Up to three (3) cycles per lifetime of gamete intrafallopian tube transfers or zygote intrafallopian tube transfers,only if the in vitro fertilization benefit has not been exhausted. Coverage for gamete intrafallopian tube transfers or zygote intrafallopian tube transfers does not count towards the in vitro fertilization benefit limit;
   - Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization.

   A “cycle” is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

4. **Fertility Preservation Services.** We Cover standard fertility preservation services when a medical treatment may directly or indirectly cause iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. “Iatrogenic infertility” means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

5. **Exclusions and Limitations.** We do not Cover:
   a. Costs associated with an ovum or sperm donor, including the donor’s medical expenses;
   b. Ovulation predictor kits;
   c. Reversal of tubal ligations;
   d. Reversal of vasectomies;
   e. Costs for services relating to surrogate motherhood that are not otherwise Covered Services under this contract;
   f. Cloning; or
   g. Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

L. Infusion Therapy. We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an

office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.

M. Interruption of Pregnancy. We Cover abortion services Coverage for abortion services includes any Prescription Drug prescribed for an abortion, including both Generic Drugs and Brand-Name Drugs, even if those Prescription Drugs have not been approved by the FDA for abortions, if the Prescription Drug is a recognized medication for abortions in one of these reference compendia:

- The WHO Model Lists of Essential Medicines;
- The WHO Abortion Care Guidelines; or
- The National Academies of Science, Engineering and Medicine Consensus Study Report.

Abortion services are not subject to Cost-Sharing.

N. Laboratory Procedures, Diagnostic Testing and Radiology Services. We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

We Cover biomarker precision medical testing, including both single-analyte tests and multiplex panel tests, performed at a participating laboratory that is either CLIA certified or CLIA waived by the FDA, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring to guide treatment decisions for Your disease or condition when one or more of the following recognizes the efficacy and appropriateness of such testing:

- Labeled indications for a test approved or cleared by the FDA or indicated tests for an FDA approved Prescription Drug;
- Centers for Medicare and Medicaid Services (“CMS”) national coverage determinations or Medicare administrative contractor local coverage determinations;
- Nationally recognized clinical practice guidelines; or
- Peer-reviewed literature and peer reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

O. Maternity and Newborn Care. We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Booklet for Coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) breast pump per pregnancy for the duration of breast feeding.

We also Cover the outpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis

P. Office Visits. We Cover office visits for the diagnosis and treatment of injury, disease and medical

conditions. Office visits may include house calls.

Specialist e-Consultations Program. If Your Participating Provider is rendering primary care services to You, he or she may conduct an electronic consultation with a Specialist to help evaluate Your condition or diagnosis. The electronic consultation will be provided by a Participating Provider in Our consultation program who will be selected by Your Participating Provider in his or her clinical judgement. The electronic consultation will be at no cost to You. Your Participating Provider may consider the information provided by the Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies such as secure web-based email, fax and/or exchange of electronic medical records. The results may be documented in an electronic health record.

Q. Outpatient Hospital Services. We Cover Hospital services and supplies as described in the Inpatient Services section of this Booklet that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

R. Preadmission Testing. We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

S. Prescription Drugs for Use in the Office and Outpatient Facilities. We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Booklet.

T. Retail Health Clinics. We Cover basic health care services provided to You on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered Services are typically provided by a physician's assistant or nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common illnesses. Retail health clinics are not a replacement for Your PCP. Your PCP should be Your first choice for care and for regular visits.

U. Rehabilitation Services. We Cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office for up to the number of visits on the Schedule of Benefits section of this Booklet.

V. Second Opinions.

1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis when Your attending Physician provides a written authorization to a non-participating Specialist

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.

a. The second opinion must be given by a board certified Specialist who personally examines You.
b. If the first and second opinions do not agree You may obtain a third opinion.
c. The second and third surgical opinion consultants may not perform the surgery on You.

4. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

W. Surgical Services. We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

Sometimes two (2) or more surgical procedures can be performed during the same operation.

1. **Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest Allowed Amount.

2. **Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
   - For the procedure with the highest Allowed Amount; and
   - 50% of the amount We would otherwise pay for the other procedures.

X. Oral Surgery. We Cover the following limited dental and oral surgical procedures:

1. Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible.
2. Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
3. Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
4. Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
5. Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

Y. Reconstructive Breast Surgery. We Cover breast or chest wall reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast or chest wall on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast or chest wall to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Chest wall reconstruction surgery includes aesthetic flat closure as defined by the National Cancer Institute. Breast or chest wall reconstruction surgery includes the tattooing of the nipple areola complex if such tattooing is performed by a Health Care Professional. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

Z. Other Reconstructive and Corrective Surgery. We Cover reconstructive and corrective surgery

other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

AA. Telemedicine Program. In addition to providing Covered Services via telehealth, We Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition.

Covered Services include a medical visit using the internet to support a secure conversation which could be via one-to-one video conversation or "text chat" with a provider. A "text chat" is an online exchange of messages. You have direct access for visits from virtual care-only Providers using Our website or mobile app. Services are provided by board certified, licensed Providers. Common types of diagnoses and conditions treated online are: cough, fever, headaches, sore throat, routine child health issues, influenza, upper respiratory infections, sinusitis, bronchitis and urinary tract infections, when uncomplicated in nature, and primary care.

Member Access. To begin a video visit or text chat through Our website at *www.anthembluecross.com*, log in to Your member account or, if You do not already have one, set up an online account by providing some basic information about You and Your insurance plan. Then, follow the prompts that will guide You to a video visit or text chat. Before You connect to a Provider, You will be asked to agree to the terms of use, and select an available Provider.

You can also begin a video visit or text chat by downloading Our mobile app from the App Store or Google Play on Your smartphone or other devices. After opening the app and registering, You will be provided the option for a video visit or a chat visit.

The visit with the Provider will not start until You provide information about You and Your insurance plan and agree to proceed. The visit will be documented in an electronic health record. You may access Your records and print them, and may email or fax them to Your Primary Care Physician.

Note about Covered Services. Telemedicine visits do not include:

- Getting reports of normal lab or other test results that were not referred to by the virtual Provider;
- Requesting an office appointment;
- Asking billing, insurance coverage or payment questions;
- Asking for a Referral to a specialist Provider;
- Requesting precertification for a benefit under Your health plan;
- Provider to Provider discussions.

BB. Transplants, Cellular and Gene Therapy Services. We Cover only those transplants and FDA approved cellular and gene therapies determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas and lung transplants; and bone marrow transplants.

All transplants, cellular and gene therapies must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated as Center of Excellence to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

A. Diabetic Equipment, Supplies and Self-Management Education. We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. **Equipment and Supplies.** We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:
    - Acetone reagent strips
    - Acetone reagent tablets
    - Alcohol or peroxide by the pint
    - Alcohol wipes
    - All insulin preparations
    - Automatic blood lance kit
    - Cartridges for the visually impaired
    - Diabetes data management systems
    - Disposable insulin and pen cartridges
    - Drawing-up devices for the visually impaired
    - Equipment for use of the pump, including batteries
    - Glucagon for injection to increase blood glucose concentration
    - Glucose acetone reagent strips
    - Glucose kit
    - Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
    - Glucose reagent tape
    - Glucose test or reagent strips
    - Injection aides
    - Injector (Busher) Automatic
    - Insulin
    - Insulin cartridge delivery
    - Insulin infusion devices
    - Insulin pump
    - Lancets
    - Oral agents such as glucose tablets and gels
    - Oral anti-diabetic agents used to reduce blood sugar levels
    - Syringe with needle; sterile 1 cc box
    - Urine testing products for glucose and ketones
    - Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

2. **Self-Management Education.** Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. **Limitations.** The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

   Step Therapy for Diabetes Equipment and Supplies. Step therapy is a program that requires You to try one type of diabetic Prescription Drug, supply or equipment unless another Prescription Drug, supply or equipment is Medically Necessary. The diabetic Prescription Drugs, supplies and equipment that are subject to step therapy include:
   - Diabetic glucose meters and test strips;
   - Diabetic supplies (including but not limited to syringes, lancets, needles, pens);
   - Insulin;
   - Injectable anti-diabetic agents; and
   - Oral anti-diabetic agents.

   If a step therapy protocol is applicable to Your request for coverage of a diabetic Prescription Drug You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Booklet. We will not add step therapy requirements to a diabetic Prescription Drug on Our Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns.

B. Durable Medical Equipment and Braces. We Cover the rental or purchase of durable medical equipment and braces.

1. **Durable Medical Equipment.**
   Durable Medical Equipment is equipment which is:
   - Designed and intended for repeated use;
   - Primarily and customarily used to serve a medical purpose;
   - Generally not useful to a person in the absence of disease or injury; and
   - Appropriate for use in the home.

   Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment.

   We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. **Braces.** We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

C. Hearing Aids.

1. External Hearing Aids. We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. Refer to the Schedule of Benefits section of this Booklet for benefit limitations.

We also Cover FDA approved over-the-counter hearing aids for Members over age 18 that are purchased as a result of a written recommendation by a Physician. Refer to the Schedule of Benefits section of this Booklet for benefit limitations.

2. Over-the-Counter Hearing Aids. We Cover over-the-counter hearing aids with a written recommendation by a Provider. We also Cover any cost-associated with the fitting and testing of such hearing aids. Please refer to the Schedule of Benefit section of the Certificate for the Cost-Sharing requirements or limits that apply to over-the-counter hearing aids.

3. Cochlear Implants. We Cover bone anchored hearing aids (i.e., cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Booklet. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

D. Hospice. Hospice Care is available if Your primary attending Physician has certified that You have twelve (12) months or less to live. You may access Hospice Care while also participating in a clinical trial or continuing treatment, as ordered by Your treating Provider. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for the number of days indicated on the Schedule of Benefits section of this Booklet. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located.

We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; homemaker or caretaker care, or respite care.

E. Medical Supplies. We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under the Plan. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under the Plan. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

F. Prosthetics:

1. **External Prosthetic Devices.** We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

   We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

   We do not Cover eyeglasses or contact lenses.

   We do not Cover shoe inserts, foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.

   We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

   Coverage is for standard equipment only.

   We Cover the cost of prosthetic devices. We also Cover the cost of repair and replacement of the prosthetic device and its parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. **Internal Prosthetic Devices:** We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

   Coverage also includes repair and replacement due to normal growth or normal wear and tear.

   Coverage is for standard equipment only.

INPATIENT SERVICES

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits.

A. Hospital Services. We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Booklet apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days for the same or related causes.

B. Observation Services. We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services. We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under the Plan.

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

E. Inpatient Stay for Maternity Care. We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically

Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under the Plan and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Booklet that apply to home care benefits.

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

F. Inpatient Stay for Mastectomy Care. We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

G. Autologous Blood Banking Services. We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

H. Habilitation Services. We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy. Coverage is limited to the number of days indicated on the Schedule of Benefits section of this Booklet.

I. Rehabilitation Services. We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy. Coverage is limited to the number of days indicated on the Schedule of Benefits section of this Booklet.

J. Skilled Nursing Facility. We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in “Hospital Services” above. Custodial, convalescent or domiciliary care is not Covered (see the “Exclusions and Limitations” section of this Booklet). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. Coverage for non-custodial care is limited to the number of days indicated on the Schedule of Benefits section of this Booklet.

K. End of Life Care. If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility’s medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited external review. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Booklet until the External Review renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:
1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility’s current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

L. Centers of Excellence. Centers of Excellence are Hospitals that We have approved and designated

for certain services. To find out if a Hospital is a Center of Excellence, call the number on Your ID card. We Cover the following Services when performed at Centers of Excellence:

- Transplants;
- Cellular and gene therapies.

M. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for you to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES

Please refer to the Schedule of Benefits section of this Booklet for Cost-Sharing requirements, day or visit limits, and any Preauthorization requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. Inpatient Services. We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical, and surgical coverage provided under the Plan. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 (10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient Facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

and, in other states, to similarly licensed or certified Facilities.

We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

2. Outpatient Services. We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. We Cover, upon the referral of a Physician, comprehensive neuropsychological examinations for dyslexia when performed by a Health Care Professional. Outpatient services also include nutritional counseling to treat a mental health condition.

Outpatient mental health care services also include outpatient care provided at a preschool, elementary, or secondary school by a school-based mental health clinic licensed pursuant to Mental Hygiene Law Article 31, regardless of whether the school-based mental health clinic is a Participating Provider. We will pay a Non-Participating Provider the amount We have negotiated

with the Non-Participating Provider for the outpatient mental health care services. In the absence of a negotiated rate, We will pay an amount no less than the rate that would be paid under the Medicaid program. However, the negotiated amount or the amount paid under the Medicaid program will not exceed the Non-Participating Provider's charge. The school-based mental health clinic shall not seek reimbursement from You for outpatient services provided at a school-based mental health clinic except for Your In-Network Cost-Sharing.

3. **Autism Spectrum Disorder.** We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, or treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

   i. **Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

   ii. **Assistive Communication Devices.** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop or tablet computers. We Cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

      We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

   iii. **Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

   iv. **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

   v. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services

are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

vi. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.

vii. **Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under New York Public Health Law Section 2545, an individualized education plan under New York Education Law Article 89, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Certificate for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

B. **Substance Use Services.** We Cover the following substance use services to treat a substance use disorder. For purposes of this benefit, “substance use disorder” means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes Coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Addiction Services and Supports (“OASAS”); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

   We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorder, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is

limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

Additional Family Counseling. We also Cover up to 20 outpatient visits per Plan Year for family counseling. A family member will be deemed to be covered, for the purpose of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from a substance use disorder; and 2) is covered under the same family Booklet that covers the person receiving, or in need of, treatment for a substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

WELLNESS BENEFITS

A. Wellness Program

1. Purpose. The purpose of Our wellness program(s) is to encourage You to take a more active role in managing Your health and well-being. These wellness-related programs are designed to help You achieve Your best health. These programs are not Covered services under Your Plan, but are separate components which are not guaranteed under Your Plan and could be discontinued at any time. Participation is voluntary, and You may elect to no longer participate at any time.

2. Description. We provide benefits in connection with the use of or participation in any of the following wellness and health promotion actions and activities:

a. Building Healthy Families. Building Healthy Families (BHF) Is a digital first program that can help support your family from preconception through pregnancy, childbirth, parenting, and early childhood (to age 5 and beyond). BHF features a library covering topics to support diverse families and provides education and support. Pregnant members receive additional support from a family care coach , as well as nurse case management for high-risk expectant members.

- **Eligibility.** The Subscriber and the Subscriber's covered Spouse or Domestic Partner age 18 and older can participate in the program and are eligible for rewards. Other covered dependents can participate in the program but are not eligible for rewards.
- **Participation.** Eligible members can sign-up by visiting Our mobile app or website *www.anthembluecross.com*. If You do not have internet access, call Us at 833-812-1776 and We will provide You with information regarding how to participate without internet access.
- You with information regarding how to participate without internet access.

b. ConditionCare Core. The ConditionCare Core program provides access to education and goal-oriented health coaching from Our clinical team. The conditions included in the ConditionCare Core program are coronary heart disease, heart failure, diabetes, asthma and chronic obstructive pulmonary disease (COPD).

- **Eligibility.** The Subscriber and the Subscriber's covered Spouse or Domestic Partner age 18 and older can participate in the program and are eligible for rewards. Other covered dependents can participate in the diabetes and asthma programs but are not eligible for rewards.
- **Participation**. Eligible members can participate in one (1) program per year. You can self-enroll in ConditionCare Core if You've been diagnosed with one of the given conditions listed above by calling Us toll free at 866-962-0951. One of Our nurse care managers will help You get started.

c. Emotional Well-being Resources Our Emotional Well-being Resources program can provide whole-health support for emotional, psychological, and social well-being concerns. The program offers self-guided Cognitive Behavioral Therapy, comprehensive self-assessments, and personalized care modules. There are also opportunities to engage with clinical coaches via text, email and phone.

- **Participation.** Eligible members age 13 and over can participate in the program but only the subscriber and the Subscriber's covered spouse or Domestic Partner age 18 and over are eligible for the reward. You may call Us toll free at the number on Your ID card. A specialist will help You get started.

d. Behavioral Health Resource. Our Behavioral Health Resource program provides individualized support from care managers to members with behavioral health conditions, such as depression and anxiety. Care managers are licensed mental health professionals whose goals are to help you take control of your health care and improve your quality of life. Members have access to:

- Our telephonic behavioral health resource center, available 24 hours a day 7 days a week, for assessment, referral, education, coaching, and crisis resolution, including depression care management, eating disorder management, and management of other complex behavioral health concerns.
- The program's online and mobile app wellness tools. These tools offer customized ways to address topics such as: stress management, anxiety, depression, substance abuse, and chronic pain. The program employs personalized tools, evidence-based resources, and individually-tailored eLearning programs to help members learn and practice new ways to manage their mental well-being.

- **Eligibility.** The Subscriber and each covered Dependent are eligible for the program.
- **Participation.** You may call Us toll free at the number on Your ID card. A care manager will help You get started. In addition, We may use claims history to identify and contact potential candidates by phone to discuss whether the program is right for them.

e. **MyHealth Advantage Gold with Alerts.** Our MyHealth Advantage Gold with Alerts program identifies and communicates gaps in care to members, including those diagnosed with the following conditions: asthma, diabetes, COPD, heart failure, coronary artery disease. Utilizing sophisticated data capabilities, MyHealth Advantage continuously analyzes member health data, such as medical and pharmacy claims as well as lab results (when available) and compares it to evidence-based best practices to identify opportunities that could generate immediate and future health costs. If We find something that You could do to improve Your health, We will send You and Your doctor a confidential letter in the mail, or a message through the program's online and mobile app tools. We do not send alerts to covered dependents under age 18 or to their parent or guardian. These messages are sent directly to the provider if any clinically significant care gaps are identified. When we notice potentially dangerous drug to drug or drug to condition risks, We alert Your doctor by telephone.

a. **Eligibility.** The Subscriber and each covered Dependent are eligible for the program.

b. **Participation.** Eligible members are automatically enrolled in this program. Call Us toll free at the number on Your ID card with any questions related to the program. Participation is voluntary, and You can discontinue the program at any time.

f. **Gym Reimbursement.** Eligible participants include the Subscriber, the Subscriber's covered Spouse or Domestic Partner, and covered dependents eighteen (18) years of age or older. Each eligible participant can receive a reimbursement for exercising no less than 35 times during a six (6) month period at a qualified fitness center that is open to the general public.

- **Participation.** To be eligible for reimbursement, eligible participants are required to exercise at the fitness center no less than 35 visits during each six (6) month period of the plan year. Only one workout session per calendar date is eligible and each workout must be at least eight (8) hours apart.

  If You become eligible after the effective date of Your benefit plan year, You can still take part in the program. Your workout session requirements and reimbursement will be prorated based on the number of months You are eligible for the program.

- **Facilities.** You have a choice for selecting a fitness center and managing Your gym reimbursement. Choose how You work out.

  - Go to a qualified fitness center, track Your workouts, and send in Your completed Fitness Center Visit Submission Form (FCVSF).

    You do not have to join a fitness center that is part of a network. You may join any qualified fitness center that is in the U.S. and open to the general public, has staff oversight and offers regular cardio, flexibility and/or weight training programs. Staff

oversight means that during normal operational hours, the fitness center has employees who oversee operations and attend to members. Class instructors do not constitute oversight.

- Online, virtual, or live-streaming fitness classes. Covered individuals that are eligible for the Gym Reimbursement Program now have the expanded option to be reimbursed for online, virtual, or live-streaming fitness classes or subscriptions. Online, virtual, at-home workout classes, live-streaming classes will be accepted and counted toward visits. Recognized online/virtual, at-home workout classes, live streaming classes are defined as one that exists for the primary purpose of improving or maintaining physical health and requires a membership fee to be billed monthly, annually or semi-annually.

- Enroll in the Active&Fit (AF) program through *anthembluecross.com*. Once enrolled, AF automatically tracks Your visits by using the AF facility's standard check in process. The AF program will manage Your reimbursement paperwork and submit a request for reimbursement after the visits are added to Your online profile.

The following services and activities do not qualify for reimbursement:

- Rehabilitation services, physical therapy services, country clubs, social clubs and sports teams or leagues;
- Fees or dues for taking part in aerobic/fitness activities;
- Fees in clubs or centers that don't qualify, as well as fees for personal training, lessons, such as tennis or swimming, courses (including boot camp), homeowner's association (HOA) fees, coaching, and exercise equipment or clothing purchases;
- Exercise sessions at fitness centers where a membership or class agreement is not offered or there is no staff oversight.

- **Reimbursement.** Participants will be reimbursed up to a total of either 1) the membership fees that are paid by a member; or 2) $200 per eligible participant twice per plan year; whichever is less. If a spouse or Domestic Partner, or dependents are also eligible participants, they too may submit for reimbursement, but only up to the annual maximum reimbursement amount indicated above. Requests for reimbursement will be paid in the order the claims are received until the maximum amount is paid. The Benefit Period is determined by Your group's effective and renewal dates. Your Benefit Period is based on twelve (12) months; therefore, this reimbursement program is based on two specific six-month periods within Your Benefit Period`. Reimbursement payments will be issued within 30 days of the receipt of the required forms. The reimbursement You receive may be considered income to You and subject to state and federal taxes in the year it is paid. The recipient is responsible for any tax consequences related to payment of the gym reimbursement amount. We recommend consulting with a tax expert on any questions regarding Your tax obligations. Submissions must be received no later than 90 days after the end of the plan year.

  You have two ways to submit the required documents:
  1. **Email.** Send an email to *Fitness@ExerciseRewards.com*. Use subject line: Gym Reimbursement Request and include electronic and scanned copies as attachments.
  2. **Mail.** Send printed copies to:
     Active&Fit ExerciseRewards
     P.O. Box 509117
     San Diego, CA 92150-9117

  You must submit the following forms in order to receive reimbursement:
  Traditional brick-and-mortar gyms and fitness centers
  1. Download and fill out the Fitness Center Visit Submission Form (FCVSF).

2. Provide a record of Your workouts. Use Your fitness center's records of Your visits or the fitness log on the back of the FCVSF. The FCVSF must also be signed by a fitness center representative.
3. Attach a receipt or credit card statement that shows payment for the months You're requesting reimbursement.

Livestream and on-demand virtual classes

1. Download and fill out the FCVSF.
2. Provide a record of Your classes. This can be print screens/screen captures showing attendance; a printed workout log form the virtual class studio; or a combination of screen captures and printed log.
3. Include a copy of Your current bill or credit card statement that shows payment for the months You're requesting reimbursement.

Send the documents via mail or email to the address on the FCVSF. Please note: The fitness center information and signature are not required on the FCVSF if You are only using online and virtual classes to earn the reimbursement.

The Fitness Center Visit Submission Form is available on Our website at *www.anthembluecross.com*. Go to My Health Dashboard, select Programs from the menu option, then go to the Gym Reimbursements section and select Learn More. If You do not have access to a computer, call Us at the number on Your ID card and We will provide You with information regarding how to participate without internet access.

EXCLUSIONS AND LIMITATIONS

No coverage is available under this Plan for the following:

A. Aviation. We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care. We do not Cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy. We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual’s coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services. We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Booklet. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Review sections of this Booklet unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico. We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services. We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Booklet.

G. Drugs That Do Not Need a Prescription. We do not cover Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin or other Drugs provided in the Diabetic Equipment, Supplies and Self-Management Education paragraph of the "Additional Benefits, Equipment and Devices" section.

H. **Experimental or Investigational Treatment.** We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Booklet, when Our denial of services is overturned by an External Appeal Agent. However, for clinical trials We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Plan for non-investigational treatments. See the Utilization Review and External Review sections of this Booklet for a further explanation of Your Appeal rights.

I. **Felony Participation.** We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

J. **Foot Care.** We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, We will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

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

L. **Government Facility.** We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

M. **Medically Necessary.** In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary.

N. **Medicare or Other Governmental Program.** We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are enrolled in Medicare, We will reduce Our benefits by the amount Medicare pays for Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not enrolled in premium-free Medicare.

O. **Military Service.** We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

P. **No-Fault Automobile Insurance.** We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Q. **Services Not Listed.** We do not Cover services that are not listed in this Booklet as being Covered.

R. **Services Provided by a Family Member.** We do not Cover services performed by a covered person’s immediate family member. “Immediate family member” means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent’s spouse, grandchild, or grandchild’s spouse.

S. Services Separately Billed by Hospital Employees. We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

T. Services with No Charge. We do not Cover services for which no charge is normally made.

U. Vision Services. We do not Cover the examination or fitting of eyeglasses or contact lenses.

V. Workers' Compensation. We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

CLAIM DETERMINATIONS

A. Claims. A claim is a request that benefits or services be provided or paid according to the terms of this Booklet. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Booklet for information on how We coordinate benefit payments when You also have health coverage with another plan.

B. Notice of Claim. Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at *www.anthembluecross.com*. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Booklet or on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Booklet; on Your ID card or visiting Our website at *www.anthembluecross.com*.

C. Timeframe for Filing Claims. Claims for services must be submitted to Us for payment within 180 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 180 day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals. We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

E. Claim Determinations. Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Booklet.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Review sections of this Booklet.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or, if information was not received, at the end of the 48-hour. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations. A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period if We deny the claim in whole or in part.

GRIEVANCE PROCEDURES

A. Grievances. Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance. You can contact Us by phone at the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination. Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 30 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 60 calendar days of receipt of Your Grievance.
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	Call Customer Service Number.

D. Grievance Appeals. If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card, in person, or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:	Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	30 calendar days of receipt of Your Appeal.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	60 calendar days of receipt of Your Appeal.

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	30 business days of receipt of all necessary information to make a determination

UTILIZATION REVIEW

A. Utilization Review. We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

Initial determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) for mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. Appeal determinations that services are not Medically Necessary will be made by: 1) licensed Physicians who are board certified or board eligible in the same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review ; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) for mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

We have developed guidelines and protocols to assist Us in this process. We will use evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card, or visit Our website at *www.anthembluecross.com*.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of receipt of the request.

   If We need additional information, we will request it within fifteen (15) calendar days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, we will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period allowed to submit the additional information.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within 72 hours of receipt of the request.

   If We need additional information, we will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to

You (or Your designee) and Your Provider, in writing, within 48 hours of the earlier of Our receipt of the additional information or the end of the 48-hour period allowed to submit additional information.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

4. **Crisis Stabilization Centers.** Services provided by participating crisis stabilization centers licensed under New York Mental Hygiene Law section 36.01 and, in other states, those which are accredited by the joint commission as alcoholism or chemical dependence substance use treatment programs and are similarly licensed, certified or otherwise authorized in the state where the Facility is located, are not subject to Preauthorization. We may review the treatment provided by crisis stabilization centers retrospectively to determine whether it was Medically Necessary, and We will use clinical review tools designated by OASAS or approved by OMH. If any treatment by a participating crisis stabilization center is denied as not Medically Necessary, You are only responsible for the In-Network Cost-Sharing that would otherwise apply to Your treatment.

5. **Preauthorization for Rabies Treatment.** Post-exposure rabies treatment authorized by a county health authority is sufficient to be considered Preauthorized by Us.

C. Concurrent Reviews

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of receipt of all necessary information.

   If We need additional information, we will request it within fifteen (15) calendar days of the receipt of the request. You or Your Provider will then have 45 calendar days to submit the additional information. We will make a determination and provide notice to You (or Your designee) and Your Provider, in writing, within fifteen (15) calendar days of Our receipt of the additional information or, if We do not receive the information, within 15 calendar days of the end of the 45-day period allowed to provide the additional information.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider within 24 hours of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination. We will make a determination and provide written notice to You (or Your designee) and Your Provider within 72 hours of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if We do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of

receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

4. **Inpatient Mental Health Treatment at Participating Hospitals or Participating Crisis Residence Facilities Licensed or Operated by the Office of Mental Health (OMH).**

   Inpatient mental health treatment at a participating Hospital as defined in New York Mental Hygiene Law Section 1.03 (10) or sub-acute mental health treatment at a participating crisis residence Facility that is licensed or operated by OMH is not subject to Preauthorization.

   If You are under 18 years of age, coverage is not subject to concurrent review for the first 14 days of the admission if the Hospital or Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission, performs daily clinical review, and participates in periodic consultation with Us to ensure that the Hospital or Facility is using the OMH approved evidence based and peer reviewed clinical review criteria utilized by Us and appropriate to Your age.

   If You are 18 years of age or older, coverage is not subject to concurrent review during the first 30 days of the admission if the Hospital or Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission, performs daily clinical review, and participates in periodic consultation with Us to ensure that the Hospital or Facility is using the OMH approved evidence based and peer reviewed clinical review criteria utilized by Us and appropriate to Your age, However, We may perform concurrent review during the first 30 days if You meet clinical criteria designated by OMH or where You are admitted to a Hospital or Facility which has been designated by OMH for concurrent review.

   Regardless of Your age, We may review the entire stay to determine whether it was Medically Necessary. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the In-Network Cost-Sharing that would otherwise apply to Your admission.

5. **Inpatient Substance Use Disorder Treatment at Participating Facilities Licensed, Certified or Otherwise Authorized by OASAS.** Inpatient substance use disorder treatment at a participating Facility that is licensed, certified or otherwise authorized by OASAS is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the In-Network Cost-Sharing that would otherwise apply to Your inpatient admission.

6. **Outpatient Substance Use Disorder Treatment at Participating Facilities Licensed, Certified or Otherwise Authorized by OASAS.** Outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating Facility that is licensed, certified or otherwise authorized by OASAS is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the Facility notifies Us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the In-Network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. Retrospective Reviews. If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within

30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services. We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration. If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider and in writing.

G. Utilization Review Internal Appeals. You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal which will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
    - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
    - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Authorization Denial.** You also have the right to Appeal the denial of a request for an authorization to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network authorization denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
    - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
    - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

H. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate Your Provider within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external review.

Substance Use Appeal. If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external review within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external review is pending.

EXTERNAL REVIEW

A. If the outcome of the mandatory first level appeal is adverse to you, and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

B. For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your identification card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

C. All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Appeal and Grievance Department
PO Box 1407
Church Street Station
New York, NY 10008-1407

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit Plan is sponsored by your Employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

COORDINATION OF BENEFITS

This section applies when You also have health coverage with another plan. When You receive a Covered service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. "Allowable expense" is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. "Plan" is other group health coverage with which We will coordinate benefits. The term "plan" includes:

- Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premium or Fees.
- Medical benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
- Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

3. "Primary plan" is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. "Secondary plan" is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment. The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy, or personal injury protection policy regardless of any election made by anyone to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies. This provision applies notwithstanding any coordination of benefits term to the contrary. The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Plan will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To

determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
- The plan of the parent who has custody will be primary;
- If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
- If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination. When this Plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information. We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment. If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment. We reserve the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans. Except as described below, We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Plan is primary, as defined in this section, We will pay benefits first.
2. If this Plan is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.
3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Plan

provide identical benefits. When the information is received, We will make any necessary adjustments.

TERMINATION OF COVERAGE

Coverage under the Plan will automatically be terminated on the first of the following to apply:

1. The Employer and/or Subscriber has failed to pay Fees within 30 days of when Fees are due. Coverage will terminate as of the last day for which Fees were paid.

2. The date on which the Subscriber ceases to meet the eligibility requirements as defined by the Employer.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Fee had been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the Child turns the maximum age indicated on the Schedule of Benefits section of this Booklet.

6. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

7. The end of the month following the Employer provision of written notice of termination of coverage to Us or such later termination date requested by the Employer's notice.

8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

9. If the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, We will rescind coverage, after 30 days' prior written notice, if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Plan.

10. The date that the Administrative Services Only Agreement between the Employer and Us terminates.

11. The Employer has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

12. The Employer has failed to comply with a material plan provision relating to Employer participation rules. We will provide written notice to the Employer and Subscriber at least 30 days prior to when the coverage will cease.

13. The Employer ceases to meet the statutory requirements to be defined as an Employer for the purposes of obtaining coverage. We will provide written notice to the Employer and Subscriber at least 30 days prior to when the coverage will cease.

14. The date there is no longer any Subscriber who lives, resides, or works in Our Service Area.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Booklet for Your right to continuation of this coverage.

EXTENSION OF BENEFITS

When Your coverage under this Plan ends, benefits stop. But, if You are totally disabled on the date the Administrative Services Only Agreement between the Employer and Us terminates, or on the date Your coverage under this Plan terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this section, total disability means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

A. When You May Continue Benefits. When Your coverage under the Plan ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to 12 months from the date Your coverage ends for Covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

B. Termination of Extension of Benefits. Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the 12-month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

C. Limits on Extended Benefits. We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Plan ends; or
- Beyond the extent to which We would have paid benefits under this Plan if coverage had not ended.

CONTINUATION OF COVERAGE

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

A. Qualifying Events. Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Plan in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
- Voluntary or involuntary termination of the Subscriber's employment;
- Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
- Divorce or legal separation from the Subscriber; or
- Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
- Voluntary or involuntary termination of the Subscriber's employment;
- Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
- Loss of covered Child status under the plan rules; or
- Death of the Subscriber.

If You want to continue coverage You must request continuation from the Employer in writing and make the Fee payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Employer.

Continued coverage under this section will terminate at the earliest of the following:
1. The date 36 months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Fees are paid if You fail to make a timely payment; or
6. The date the Administrative Services Only Agreement between the Employer and Us terminates. However, if the Administrative Services Only Agreement is replaced with similar coverage, You have the right to become covered under the new Plan for the balance of the period remaining for Your continued coverage.

B. Supplementary Continuation, and Temporary Suspension Rights During Active Duty.

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Employer does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
2. You serve no more than four (4) years of active duty.

When Your Employer does not voluntarily maintain Your coverage during active duty, coverage under the Plan will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Employer the required Fee but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Plan may be resumed as long as You are reemployed or restored to participation in Your Employer's Plan upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Employer's Plan upon return to civilian status, You will be eligible for continuation as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

SUBROGATION AND REIMBURSEMENT

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

A. Definitions

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

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

B. Subrogation

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

C. Reimbursement

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

D. Secondary to Other Coverage

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

E. Assignment

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

F. Applicability to All Settlements and Judgments

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

G. Constructive Trust

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

H. Lien Rights

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

I. First-Priority Claim

By accepting benefits from the Plan, You acknowledge the Plan's rights under these Subrogation and Reimbursement provisions are a first priority claim and are to be repaid to the Plan before You receive

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

J. Cooperation

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

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to You occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to Your injury, illness or condition.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation.
- You recognize that to the extent that the Plan paid or will pay benefits under a capitated agreement, the value of those benefits for purposes of these provisions will be the reasonable value of those payments or the actual paid amount, whichever is higher.
- You must not do anything to prejudice the Plan's rights under these Subrogation and Reimbursement provisions. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.
- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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

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

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

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

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

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

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

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

K. Discretion

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

GENERAL PROVISIONS

1. **Agreements Between Us and Participating Providers.** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Plan does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. **Assignment.** You cannot assign any benefits under the Plan or legal claims based on a denial of benefits or request for plan documents to any person, corporation, or other organization and any such assignment will be void and unenforceable. You cannot assign any monies due under the Plan to any person, corporation or other organization unless it is an assignment to Your Non-Participating Provider licensed under New York Public Health Law Article 30 for services described in the Ambulance and Pre-Hospital Emergency Medical Services Section of this Booklet.

   Assignment means the transfer to another person, corporation or other organization of Your right to the services provided under the Plan or Your right to collect money from Us for those services or Your right to sue based on a denial of benefits or request for plan documents. Any purported assignment of benefits shall be void. Any purported assignee of benefits shall acquire no rights by reason of any such purported assignment. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. **Changes in This Booklet.** We may unilaterally change this Booklet upon renewal, if We give the Employer 30 days' prior written notice.

4. **Clerical Error.** Clerical error, whether by the Employer or Us, with respect to this Plan, or any other documentation issued by Us in connection with this Plan, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

5. **Conformity with Law.** Any term of this Plan which conflicts with any applicable federal law will be amended to conform with the minimum requirements of such law.

6. **Continuation of Benefit Limitations.** Some of the benefits in this Plan may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Subscriber.

7. **Enrollment ERISA.** The Employer will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Members covered under this Plan, and any other information required to confirm their eligibility for coverage.

   The Employer will provide Us with this information upon request. The Employer may also have additional responsibilities as the "plan administrator" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended. The "plan administrator" is the Employer, or a third party appointed by the Employer. We are not the ERISA plan administrator

   The Employer will provide Us with the enrollment form including Your name, address, age, and social security number and advise Us in writing when You are to be added to or subtracted from Our list of covered persons, on a monthly basis, on or before the same date of the month as the effective date of the Administrative Services Agreement with Us. If the Employer fails to so advise Us, the Employer will be responsible for the cost of any claims paid by Us as a result of such failure. In no event will retroactive additions to or deletions from coverage be made for periods in excess of thirty (30) days.

8. **Entire Agreement.** This Booklet, including any endorsements, riders and the attached applications, if any, constitutes the entire Plan.

9. **Fraud and Abusive Billing.** We have processes to review claims before and after payment to detect fraud and abusive billing.

   Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

10. **Furnishing Information and Audit.** The Employer and all persons covered under this Plan will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Plan. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Employer will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Employer enrollment at the Employer's New York office.

11. **Identification Cards.** Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Plan. To be entitled to such services or benefits, Your Fees must be paid in full at the time the services are sought to be received.

12. **Incontestability.** No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties

13. **Independent Contractors**. Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's Facility.

14. **Input in Developing Our Policies.** Subscribers may participate in the development of Our policies by calling or writing to Member Services. We encourage You to send suggestions about how We may improve Our products or Our policies and procedures. Also, We regularly conduct customer satisfaction surveys that permit You to share Your suggestions and opinions with Us.

15. **Material Accessibility.** We will give the Employer, and the Employer will give You, ID cards, Booklets, riders, and other necessary materials

16. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Plan. Upon Your request, We will provide the following information:
    - A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
    - The information that We provide the State regarding Our consumer complaints.
    - A copy of Our procedures for maintaining confidentiality of Member information.
    - A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Plan.
    - A written description of Our quality assurance program.
    - A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
    - Provider affiliations with participating Hospitals.
    - A copy of Our clinical review criteria (e.g. Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or

Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under this Plan.

17. **Notice.** Any notice that We give You under this Plan will be mailed to Your address as it appears in Our records or to the address of the Employer. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: Anthem Member Services, P.O. Box 1407, Church Street Station, New York, NY 10008.

18. **Premium Refund.** We will give any refund of Fees, if due, to the Employer.

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

20. **Recovery of Overpayments.** On occasion a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

21. **Renewal Date.** The renewal date for this Plan is the anniversary of the effective date of the Employer Administrative Services Only Agreement of each year. This Plan will automatically renew each year on the renewal date unless otherwise terminated by Us or the Employer as permitted by this Plan.

22. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will or will not make payments under this Plan. Examples of the use of the standards are to determine whether. Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Booklet. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Plan.

    We review and evaluate new technology according to technology evaluation criteria developed by Our medical directors and reviewed by a designated committee, which consists of Health Care Professionals from various medical specialties. Conclusions of the committee are incorporated into Our medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a Covered benefit.

23. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

24. **Service Marks.** Anthem HealthChoice Assurance, Inc. (“Anthem”) is an independent corporation organized under the New York Insurance Law. Anthem also operates under licenses with the Blue Cross and Blue Shield Association, which licenses Anthem to use the Blue Cross and/or Blue Shield service marks in a portion of New York State. Anthem does not act as an agent of the Blue Cross and Blue Shield Association. Anthem is solely responsible for the obligations created under this agreement.

25. **Severability.** The unenforceability or invalidity of any provision of this Plan shall not affect the validity and enforceability of the remainder of this Plan.

26. **Significant Change in Circumstances**. If We are unable to arrange for Covered Services as provided under this Plan as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

27. **Third Party Beneficiaries.** No third party beneficiaries are intended to be created by this Plan and nothing in this Plan shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Plan. No other party can enforce this Plan’s provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Plan, or to bring an action or pursuit for the breach of any terms of this Plan.

28. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Plan. You must start any lawsuit against Us under this Plan within two (2) years from the date the claim was required to be filed.

29. **Venue for Legal Action.** If a dispute arises under this Plan, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

30. **Waiver.** The waiver by any party of any breach of any provision of this Plan will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

31. **Who May Change This Plan.** This Plan may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Plan in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.

32. **Who Receives Payment Under This Plan.** Payments under this Plan for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either the Subscriber or the Provider. However, We will directly pay a Provider instead of You for Emergency Services, including inpatient services

following Emergency Department Care, air ambulance services, and surprise bills. For pre-hospital emergency medical services, emergency ground and water ambulance transportation, and non-emergency ambulance transportation, if You assign benefits to a Non-Participating Provider licensed under New York Public Health Law Article 30, We will pay the Non-Participating Provider directly. If You do not assign benefits to a Non-Participating Provider licensed under New York Public Health Law Article 30, We will pay You and the Non-Participating Provider jointly.

33. **Workers' Compensation Not Affected.** The coverage provided under this Plan is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

34. **Your Medical Records and Reports.** In order to provide Your coverage under this Plan, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Plan, except as prohibited by law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:
    - Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
    - Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
    - Permit copying of Your medical records by Us.

    We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted by law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Plan, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

35. **Your Rights and Responsibilities.**
    - You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.
    - You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.
    - You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
    - You have the right to formulate advance directives regarding Your care.
    - You have the right to access Our Participating Providers.

    As a Member, You should also take an active role in Your care. We encourage You to:
    - Understand Your health problems as well as You can and work with Your Providers to make a treatment plan that You all agree on;
    - Follow the treatment plan that You have agreed on with Your doctors or Providers;
    - Give Us, Your doctors and other Providers the information needed to help You get the care You need and all the benefits You are eligible for under Your Booklet. This may include information about other health insurance benefits You have along with Your coverage with Us; and
    - Inform Us if You have any changes to Your name, address or Dependents covered under Your Booklet.

For additional information regarding Your rights and responsibilities, visit Our website at *www.anthembluecross.com* (see “Laws and Rights that Protect You” under FAQs). If You do not have internet access, You can call Us at the number on Your ID card to request a copy. If You need more information or would like to contact Us, please go to Our website at *www.anthembluecross.com* or call Us at the number on Your ID card.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish
Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. 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
Ky njoftim përmban informacion të rëndësishëm rreth aplikimit ose përfitimeve tuaja. Shihni datat kryesore. Mund t'ju nevojitet të veproni brenda afateve të caktuara për të vazhduar të përfitoni ose për të menaxhuar kostot. 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)

Arabic
يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD:711).

Bengali
আপনার আবেদন বা সুবিধার বিষয়ে এই বিজ্ঞপ্তিটিতে গুরুত্বপূর্ণ তথ্য রয়েছে। গুরুত্বপূর্ণ তারিখগুলির জন্য দেখুন। আপনার সুবিধাগুলি বজায় রাখার জন্য বা খরচ নিয়ন্ত্রণ করার জন্য নির্দিষ্ট তারিখে আপনাকে কাজ করতে হতে পারে। বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আপনার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Chinese
本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。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)

French
Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. 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)

Greek
Αυτή η ειδοποίηση περιέχει σημαντικές πληροφορίες για την εφαρμογή σας ή τις παροχές σας. Αναζητήστε τις σημαντικές ημερομηνίες. Ενδέχεται να χρειαστεί να κάνετε κάποιες ενέργειες μέχρι συγκεκριμένες ημερομηνίες, ώστε να διατηρήσετε τις παροχές σας ή να διαχειριστείτε το κόστος. 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 (ID card) για βοήθεια. (TTY/TDD: 711)

Haitian
Avi sa a gen enfòmasyon enpòtan sou aplikasyon ou an oswa avantaj ou yo. Veye dat enpòtan yo. Ou ka bezwen pran aksyon avan sèten dat pou kenbe avantaj ou yo oswa jere depans ou yo. 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)

Italian
Il presente avviso contiene informazioni importanti relative alla domanda da lei presentata o ai benefici a lei riservati. Consulti le date importanti riportate. Per continuare a usufruire dei benefici o ricevere assistenza per il pagamento delle spese, potrebbe dover eseguire determinate azioni entro scadenze specifiche. 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)

Korean
이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴 보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Polish
Niniejsze powiadomienie zawiera istotne informacje dotyczące wniosku lub świadczeń. Zwróć uwagę na ważne daty. Zachowanie świadczeń lub zarządzanie kosztami może wymagać podjęcia dodatkowych działań w konkretnych terminach. Masz prawo do bezpłatnego otrzymania stosownych 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)

Russian
Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте.
(TTY/TDD: 711)

Tagalog
May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu
یہ نوٹس آپ کی درخواست یا فائدوں کے بارے میں اہم معلومات پر مشتمل ہے۔ اہم تاریخیں دیکھیے۔ اپنے فائدوں یا لاگتوں کو منظم کرنےکے لیے آپ کو بعض تاریخوں پر اقدام کرنے کی ضرورت ہوسکتی ہے۔ آپ 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)

Yiddish
דעם מעלדונג האט וויכטיגע אינפארמאציע וועגן אייער אפלעקאציע אדער קאווערידזש. קוקט פאר נויטיגע דאטעס אין דעם מעלדונג. איר וועט מעגליך דארפן נעמען אקציע קודם געוויסע דעדליינז צו האלטן אייערע געזונט קאווערידזש אדער העלפן מיט קאסט. איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. רופט די מעמבער באדינונגען נומער אויף אייער קארטל פאר הילף(TTY/TDD:711).

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 ID 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.