

THE COMPREHENSIVE CARE HEALTHCARE PLAN



"Creating A More Educated Georgia"

**THE
UNIVERSITY
SYSTEM OF
GEORGIA**

RESOURCE CONTACTS

Should you have questions regarding your Comprehensive healthcare plan benefits, please contact the appropriate resource(s) identified below:

For Questions About:	Please Contact	Location
<p style="text-align: center;">Claims/Coverage Provided by the Plan</p> <p style="text-align: center;">For information regarding the participating providers.</p>	Accolade	1-866-204-9818 TDD 711
<p style="text-align: center;">Online Tools and Online Provider Directory</p>	Accolade	member.accolade.com
<p style="text-align: center;">Pre-certification for Specific Outpatient/All Inpatient Hospital Services</p>	Anthem Blue Cross and Blue Shield	1-800-233-5765 TDD/1-800-368-4424
<p style="text-align: center;">Accolade NurseLine After hours assistance only</p> <p>For emergency room referral and for medical information from a registered nurse, 24-hours a day, seven days a week.</p>	Accolade	1-866-204-9818 TDD 711
<p style="text-align: center;">Centers of Excellence Transplant Program</p>	Anthem Blue Cross and Blue Shield	1-800-824-0581 TDD/1-800-368-4424
<p style="text-align: center;">Behavioral Health & Substance Abuse Providers/Facilities</p>	Anthem Blue Cross and Blue Shield	Call the number located on your identification card. 1-800-292-2879
<p style="text-align: center;">Pharmacy Benefits</p>	CVS/Caremark	1-877-362-3922
<p style="text-align: center;">HIPAA</p>	Secretary	U.S. Dept. of Health and Human Services Office of Civil Rights, Region IV 61 Forsyth St. SW, Suite 3B70 Atlanta, GA 30303-8909 404-562-7886 (metro Atlanta) 1-866-627-7748 (outside of metro Atlanta)

University System of Georgia benefits website: <https://benefits.usg.edu/>

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INTRODUCTION

The booklet describes the University System of Georgia Comprehensive Care Healthcare Benefits Plan (the Plan), available to employees and pre-Medicare retirees of the University System of Georgia (USG), as it is in effect as of January 1, 2023.

Your healthcare plan is designed with two important goals in mind. The primary purpose of the healthcare plan is to provide you and your family with access to medical care in the event of an illness or serious injury. Your Comprehensive Care healthcare plan will offset member costs for medically necessary treatment of covered illnesses and/or injuries.

The second goal of the Plan is to encourage covered members and their families to take an active role in decisions regarding their healthcare. Your involvement begins with reading this booklet and with learning how the Comprehensive Care healthcare plan works. It is your responsibility to make efficient use of the coverage provided by the plan. Should you have questions regarding your benefits, as presented in this booklet, please contact your campus Human Resources/Benefits Office or the appropriate vendor. Vendors are listed on the inside front cover of this plan summary document. This Benefit Booklet uses a number of capitalized terms that are defined in the "Definitions" section of this Benefit Booklet. Please refer to the Definitions section for an explanation of these terms. Also, keep in mind that this Benefit Booklet is a summary only; it does not describe every aspect of the Plan that may affect your benefits.

How to Get Language Assistance

Accolade is committed to communicating with Members no matter what their language is. Accolade employs a language line interpretation service for use by all their Member Support team. Simply call the phone number on the back of your Identification Card, and a representative will be able to help you. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

COMPREHENSIVE CARE PLAN BENEFIT AT A GLANCE

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

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

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

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

There is no pre-existing condition waiting period.

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 Billing Act Requirements

Emergency Services

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

- Without the need for Pre-certification;
- 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 Allowable 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 claims will be paid at the Out-of-Network benefit level if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges. 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 Allowable Amount and the Out-of-Network Provider's billed charges. This requirement does not apply to Ancillary Services. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) pathology; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (I) Hospitalists; (J) Intensivists; and (K) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this notice and consent process to you if Anthem does not have an In-Network Provider in your area who can perform the services you require.

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.

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. In addition to your In-Network cost-shares, the Out-of-Network Provider can also charge you for the difference between the Maximum Allowed Amount and their billed charges.

How Cost-Shares Are Calculated

Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. 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 will be applied to your In-Network Out-of-Pocket Limit.

Appeals

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

Transparency Requirements

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

- 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 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all In-Network Providers.

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

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

□

BENEFITS AT A GLANCE

Provided for your information is a summary of selected benefits that are available to you and your family under the plan:

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>In-Network</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i>
<p><u>Maximum Annual Deductible</u></p> <ul style="list-style-type: none"> • Individual • Individual + 1 • Family (3 or more covered members) 	<p>\$1,000</p> <p>\$2,000</p> <p>\$3,000</p>	<p>\$3,000</p> <p>\$6,000</p> <p>\$9,000</p>
<p>Members who use both In-Network providers and Out-of-Network providers will be responsible for two separate Deductibles and for two separate Out-of-Pocket Maximums.</p> <p><i>The deductible and out-of-pocket maximum are embedded meaning no one member will pay more than the individual deductible and individual out-of-pocket maximum.</i></p> <p>Deductibles, Out-of-Pocket Maximums, and annual visit limitations will be based on a January 1 - December 31 plan year.</p> <p>Prescription drugs have a separate Deductible and Out-of-Pocket Maximum. Refer to the "Pharmacy Benefit Management ("PBM")" section of this booklet for information on prescription drug benefits.</p>		
<p><u>Out-of-Pocket Maximum</u> (includes the Deductible, member copays and member coinsurance)</p> <ul style="list-style-type: none"> • Individual • Individual + 1 • Family (3 or more covered members) 	<p>\$2,250</p> <p>\$4,500</p> <p>\$4,500</p>	<p>\$6,750</p> <p>\$13,500</p> <p>\$13,500</p>
<p>Member Copayments for physician office visits and for emergency room services do not apply toward the annual Deductible(s).</p> <p>Member Copayments for physician office visits and emergency room services apply toward the Out-of-Pocket Maximum.</p> <p>Member costs incurred for Balance Billing will not apply toward the annual Deductible(s) or toward the Out-of-Pocket Maximums.</p>		

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>In-Network</i> <i>Subject to In-Network Deductible Unless Otherwise Noted</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i> <i>Subject to Out-of-Network Deductible and Balance Billing Unless Otherwise Noted</i>
Pre-Existing Conditions	None	
Physician Services Provided In An Office Setting (including In-Person and/or Virtual Visits)		
<ul style="list-style-type: none"> • Physician Office Visit For treatment of illness or injury • Specialist Office Visit • LiveHealth Online Visit • LiveHealth Online Behavioral Health Visit • Retail Health Clinic 	<p>The \$20 Copayment applies to the physician's office visit <i>only</i>.</p> <p>The \$20 Copayment does not apply to covered charges associated with medical treatment/services. (Medical treatment/services may include services such as surgery, X- rays, laboratory tests, and/or diagnostic tests.)</p> <p>\$35 Copayment applies to office visit only</p> <p>\$0 for the first 3 visits, then \$15 copay per visit</p> <p>\$0 for the first 3 visits, then \$15 copay per visit</p> <p>\$15 Copayment</p>	<p>60% of eligible charges for <u>non-surgical</u> services</p> <p>60% of eligible charges for non- surgical services</p> <p>N/A</p> <p>N/A</p> <p>N/A</p>
Wellness Care/Preventive Healthcare <i>Physical Exam, Mammogram, Pap Smear, Other Women's Preventive Care, Prostate Exam/PSA, Well-baby care and Immunizations, Routine Eye and Hearing Exams</i>	Paid at 100% of network rate; not subject to Deductible.	60% of eligible charges

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>In-Network</i> <i>Subject to In-network Deductible Unless Otherwise Noted</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i> <i>Subject to Out-of-Network Deductible and Balance Billing Unless Otherwise Noted</i>
<p>Maternity Care <i>(Routine Prenatal care, Delivery and Postnatal)</i></p> <p>*Unless covered as preventive care</p>	<p>90% of network rate after an initial Copayment of \$20; for in office setting; not subject to Deductible.</p> <p>There will be no Copayment charged for subsequent visits.</p>	<p>60% of eligible charges</p>
<p>Office Surgery</p> <p><i>Pre-certification may be required.</i></p>	<p>90% of network rate</p>	<p>60% of eligible charges</p>
<p>Second Surgical Opinion <i>(Elective Surgery)</i></p>	<p>100% of network rate after a \$20 Copayment per visit; not subject to Deductible.</p>	<p>60% of eligible charges</p>
<p>Allergy Testing</p>	<p>90% of network rate</p>	<p>60% of eligible charges</p>
<p>Allergy Shots & Serum</p>	<p>100% for allergy shots & serum; not subject to Deductible. If a physician is seen, the visit is treated as an office visit and is subject to a \$35 Copayment per visit.</p>	<p>60% of eligible charges</p>
Inpatient Hospital Services		
<p>Inpatient Hospital Services</p> <ul style="list-style-type: none"> Physician Services <p>Physician services may include surgery, anesthesiology, pathology, radiology and/or maternity care/delivery.</p> <p>Pre-certification may be required.</p>	<p>90% of network rate</p> <p>In some instances, you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In- Network cost share amounts for those Covered Services.</p>	<p>60% of eligible charges</p>

<p>SELECTED PLAN FEATURES AND COVERED SERVICES</p>	<p>PLAN PROVISIONS AND BENEFITS</p> <p><i>In-Network</i></p> <p><i>Subject to In-network Deductible Unless Otherwise Noted</i></p>	<p>PLAN PROVISIONS AND BENEFITS</p> <p><i>Out-of-Network</i></p> <p><i>Subject to Out-of-Network Deductible and Balance Billing Unless Otherwise Noted</i></p>
<p>Hospital Services Other Than Those For Emergency Room Care</p> <p>Inpatient Care (Includes inpatient short term rehabilitation services)</p> <p><i>Pre-certification may be required.</i></p>	<p>90% of network rate; limited to semi-private room;</p>	<p>60% of eligible charges;</p>
<p>Care in a Hospital Emergency Room (ER)</p> <p><i>For treatment of an emergency medical condition or injury</i></p>	<p>90% of network rate after a \$300 Copayment per visit</p> <p>Copayment is waived if admitted within 24 hours.</p>	<p>90% of eligible charges after a \$300 Copayment per visit; <i>subject to the In-Network Deductible</i></p> <p>Copayment is waived if admitted within 24 hours.</p>
<p>Laboratory Services</p> <p><i>Pre-certification for diagnostic testing may be required.</i></p>	<p>90% of network rate</p>	<p>60% of eligible charges</p>
<p>Urgent Care Services</p>	<p>100% of network rate after a \$35 Copayment per visit; <i>not subject to Deductible.</i></p>	<p>60% of eligible charges</p>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>In-Network</i> <i>Subject to In-network Deductible Unless Otherwise Noted</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i> <i>Subject to Out-of-Network Deductible and Balance Billing Unless Otherwise Noted</i>
<p>Home Health Care Service</p> <p>Home Health Care Visits from a Home Care Agency</p> <ul style="list-style-type: none"> • Home Dialysis • Home Infusion Therapy/Chemotherapy • Specialty Prescription Drugs • Other Home Health Care Services/Supplies <p><i>Pre-certification may be required.</i></p>	90% of network rate	60% of network rate
<p>Skilled Nursing Facility</p> <p><i>Pre-certification is required.</i></p>	90% of network rate Limited to 30 days per member per year.	60% of eligible Limited to 30 days per member per year.
<p>Hospice Care</p>	100% of network rate	60% of eligible charges
<p>Cochlear Implants</p> <p><i>Pre-certification is required.</i></p>	90% of network rate	60% of eligible charges
<p>Hearing aids for covered dependent children 18 years old and under</p>	90% of network rate Initial: 1 hearing aid per ear with a limit of \$3000 per ear Replacement: 1 hearing aid per ear every 48 months	60% of eligible charges Initial: 1 hearing aid per ear with a limit of \$3000 per ear Replacement: 1 hearing aid per ear every 48 months

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>In-Network</i> <i>Subject to In-network Deductible Unless Otherwise Noted</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i> <i>Subject to Out-of-Network Deductible and Balance Billing Unless Otherwise Noted</i>
Wigs (when medically necessary)	90% of network rate	60% of eligible charges
Ambulance Services (Air) <i>Ambulance for medically necessary emergency transportation only.</i> Important Note: All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.	90% of network rate; subject to Deductible.	90% of eligible charges; subject to the In-Network Deductible. <i>Except as set forth in the Surprise Billing Legislation Notice, or as otherwise specified in this Booklet, Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount.</i>
Ambulance Services (Ground and Water) <i>Ambulance for medically necessary emergency transportation only.</i> Important Note: All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "Getting Approval for Benefits" for details.	90% of network rate; subject to Deductible; subject to balance billing for out-of-network services.	90% of eligible charges; subject to the In-Network Deductible and Balance Billing.
Durable Medical Equipment (DME), Medical Devices and Supplies <i>Plan may require approved Letter of Medical Necessity and Pre-certification may be required.</i> Wigs (subject to Medical Necessity)	90% of network rate	60% of network rate

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>In-Network</i> <i>Subject to In-network Deductible Unless Otherwise Noted</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i> <i>Subject to Out-of-Network Deductible and Balance Billing Unless Otherwise Noted</i>
Outpatient Short Term Rehabilitation Services	90% of network rate Physical, speech, cardiac and occupational therapies are limited to 40 visits per therapy type per plan year.	60% of eligible charges Physical, speech, cardiac and occupational therapies are limited to 40 visits per therapy type per plan year.
Chiropractic Care	90% of network rate Limited to 40 visits per member per plan year.	60% of eligible charges Limited to 40 visits per member per plan year.
<ul style="list-style-type: none"> Dental/Oral Care <p><i>Not covered; other than accidental injury to natural teeth. (Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to, accidental bodily injury to sound natural teeth or structure occurring while a member is covered by this contract and performed within 180 days after the accident.)</i></p> <p><i>Please Note: Outpatient charges and anesthesia for dental services for children may be covered but will require prior approval.</i></p> <p>Does not include services for the removal of impacted wisdom teeth.</p>	<p>90% of network rate; subject to In-Network Deductible and to Balance Billing if services are rendered by an Out-of-Network Provider.</p> <p><i>In-Network Providers may not be available for all covered services.</i></p>	60% of eligible charges

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>In-Network</i> <i>Subject to In-network Deductible Unless Otherwise Noted</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i> <i>Subject to Out-of-Network Deductible and Balance Billing Unless Otherwise Noted</i>
<p><u>Mental Health/Substance Abuse Services</u></p> <ul style="list-style-type: none"> ▪ Inpatient mental health and substance abuse services* (facility and physician fee) <p>Residential Treatment Center*</p> <ul style="list-style-type: none"> ▪ Partial Hospitalization Program (PHP) and Intensive Outpatient Program (IOP)* (facility and physician fee) <ul style="list-style-type: none"> ▪ Office mental health and substance abuse services (physician fee – including Online visits and Intensive In-Home Behavioral Health Programs) <p style="padding-left: 40px;">*Please see the “Office Visits” section for Mental Health and Substance Abuse Virtual Visits received from our Online Provider LiveHealth Online.</p> <ul style="list-style-type: none"> ▪ Outpatient mental health and substance abuse services (physician fee) <p>(*services must be authorized by calling 1-800-292-2879. Failure to pre-certify will result in denial of benefits.)</p>	<p style="text-align: center;">90% of network rate</p> <p style="text-align: center;">90% of network rate</p> <p style="text-align: center;">90% of network rate</p> <p style="text-align: center;">\$20 Copayment</p> <p style="text-align: center;">90% of network rate</p>	<p style="text-align: center;">60% of network rate</p> <p style="text-align: center;">60% of network rate</p> <p style="text-align: center;">60% of network rate</p> <p style="text-align: center;">60% of network rate</p> <p style="text-align: center;">60% of network rate</p>

SELECTED PLAN FEATURES AND COVERED SERVICES	PLAN PROVISIONS AND BENEFITS <i>In-Network</i> <i>Subject to In-network Deductible Unless Otherwise Noted</i>	PLAN PROVISIONS AND BENEFITS <i>Out-of-Network</i> <i>Subject to Out-of-Network Deductible and Balance Billing Unless Otherwise Noted</i>
Autism / Applied Behavioral Analysis (ABA) Therapy	\$20 Copay then 100% of network rate; not subject to Deductible	60% of network rate
<p><u>Organ and Tissue Transplants</u></p> <p><i>The Centers of Excellence Programs direct patients to network heart, liver, lung and bone marrow transplant specialists.</i></p> <p>Prior approval may be required.</p>	<p><i>In-Network:</i> 90% of vendor network rate at a contracted transplant center; <i>subject to In-Network Deductible</i></p>	<p><i>Out-of-Network:</i> 60% of Covered Services at a non-contracted transplant center; <i>subject to Out-of-Network Deductible and to Balance Billing.</i></p> <p>The lifetime benefit limit for expenses related to a <i>donor search</i>, when using a contracted transplant Center, is \$10,000</p> <p><i>There will be no donor search benefit provided if an individual uses a non-contracted transplant center.</i></p> <p>For additional information regarding the COE Program for organ and tissue transplants, please contact Anthem at 1-866-694-0724.</p> <p>Centers of Excellence (COE) Transplant Providers</p> <p>Blue Distinction Center Facility: Blue Distinction facilities have met or exceeded national quality standards for care delivery.</p> <p>Centers of Medical Excellence (CME): Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery.</p> <p>In-Network Transplant Provider: Providers who have achieved designation as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant.</p> <p>Out of Network (PAR) Transplant Provider: Providers participating in the Plan's networks but not designated as a Centers of Medical Excellence for Transplant or Blue Distinction Center + or Blue Distinction Center for Transplant.</p>

OUT OF COUNTRY

Subject to the In-Network Deductible
Plan pays 90% of Network Rate; may be subject to Balance Billing and charges for non-Covered Services.

Note: All plan exclusions and limitations still apply.

The University System of Georgia Comprehensive Care healthcare plan does not have the legal authority to intervene when an Out-of-Network Provider Balance Bills the member. Therefore, the Plan cannot reduce or eliminate Balance Billed amounts. The Plan will not make additional payments above the Plan- allowed benefit limits. *If you believe you were balance billed in violation of the No Surprises Act, you may wish to contact the appropriate governmental oversight agency for assistance.*

WHO CAN ENROLL

As an active benefits-eligible employee of the University System of Georgia with a work commitment of three-quarters time (30 hours per week) or more, you are eligible for coverage under the Comprehensive Care Healthcare Plan. You can cover your eligible dependents which include:

- Legal spouse;
- The Employee’s dependent children until the end of the month in which he/she attains age 26 unless disabled. "Child" for this purpose includes legally adopted children from the date the Employee assumes legal responsibility, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee’s children (or children of the Employee’s Spouse) for whom the Employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the Employee for support, regardless of age. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Plan immediately prior to reaching age 26. Certification of the disability is required within 30 days of attainment of age 26. A certification form is available from the Employer or from the Claims Administrator and may be required periodically.

The completed enrollment must include the legal names, birth dates and Social Security numbers (with the exception of newborns) of any enrolled family member.

Documentation is required to add dependents to your coverage. Common examples include a marriage certificate, birth certificate, income tax return and/or joint utility. Visit oneusgconnect.usg.edu for a complete list of requirements. You must submit such documentation within the timeframes established by the plan administrator.

If you have a dependent(s) employed by the University System of Georgia, and your dependent(s) is participating in any University System of Georgia healthcare plan, you *may not* cover that dependent(s) under your “Employee + Child(ren),” “Employee + Spouse,” or “Family” coverage.

If your spouse is employed by the University System of Georgia, but he/she does not elect to participate in an available healthcare plan, you may cover him/her under your “Employee + Spouse” or “Family” coverage.

If both a husband and wife are benefits-eligible employees of the University System of Georgia, only one may elect to provide coverage for the other spouse and/or dependents.

The Comprehensive Care Healthcare Plan provides four levels of coverage:

Single	Employee Child(ren) +	Employee Spouse +	Family
Employee Only	Employee Child(ren) +	Employee + Spouse	Employee + Spouse and Child(ren)

HOW TO ENROLL

You must complete the enrollment process for healthcare coverage. To enroll, visit www.oneusgconnect.usg.edu, select Manage My Benefits, and click the Change Your Coverage tile or Call OneUSG Connect - Benefits Call center at 1-844-587-4236. 8am - 5pm, EST, Monday – Friday. You may obtain benefit information by visiting oneusgconnect.usg.edu.

WHEN EMPLOYEE COVERAGE BEGINS

As a benefits eligible Employee of the University System of Georgia, you have 30 days from your effective date of employment or new eligibility to enroll for coverage in a healthcare plan. If you enroll in this Plan within 30 days of your employment date, you will be covered by the plan as of the first day of the month following enrollment unless enrollment is on the first calendar day of the month, in which case coverage becomes effective upon enrollment. For those Employees covered under an academic contract, you have 30 days from your contract date to enroll. Benefits will begin on the first day of the contract if enrolled on or before that day or on the first day of the month following enrollment if they enroll after the contract start.

WHEN DEPENDENT COVERAGE BEGINS

If an eligible Dependent is enrolled in the Plan when the Employee is under Employee + Child(ren), Employee + Spouse or Employee + Family coverage, the Dependent's coverage is effective at the same time that the Employee's coverage is. If a Dependent is enrolled later, the Dependent will become covered on the first of the month following his/her enrollment, except that an Employee, Spouse or child who is enrolled within 30 days of that child's birth, adoption or placement for adoption will be covered effective as of the date of birth, adoption or placement for adoption.

You will be required to ensure that your Dependents, including newborns, are enrolled in the Plan even if you already have Employee + Family coverage. Otherwise, your Dependent will not be covered under the Plan. Contact OneUSG Connect-Benefits to make the applicable qualifying life event and provide supporting documents within 30 days of the event. USG OPEN ENROLLMENT PERIOD

Open enrollment is generally held during the fall of each calendar year. Your Human Resources/Benefits Office will advise you of the specific dates for the University System of Georgia's open enrollment period.

Healthcare plan elections made during an open enrollment period will become effective at the beginning of a new plan year. The plan year for the University System of Georgia is currently a calendar year (January 1
• December 31).

During an open enrollment period, an Employee may elect to: (1) enroll in a healthcare plan; (2) drop healthcare coverage; (3) participate in a different healthcare plan option; and/or (4) change his/her level of coverage (i.e., Employee Only, Employee + Child(ren), Employee + Spouse, or Family). Members who have COBRA coverage will have the same open enrollment period and options.

THE COST OF YOUR HEALTHCARE COVERAGE

The University System of Georgia pays a significant portion of the cost of your coverage under this Plan. Your enrollment kit will include information on the cost of this Plan as well as any other option that is available to you. Your campus Human Resources/Benefits Office will notify you of any changes in the cost to you of Plan coverage, although it is unlikely that there would be a mid-year change. Your premium depends upon the level of coverage (employee only, employee + one child, employee + spouse, or family) that you select. Active Employees (as opposed to retirees) will pay their share of the cost of coverage with pre-tax dollars, whenever possible.

QUALIFYING EVENTS FOR CHANGES IN HEALTHCARE PLAN COVERAGE

If you are an active Employee, your share of the cost for healthcare plan premiums is paid with **pre-tax** dollars. Accordingly, the Internal Revenue Services (IRS) has established strict rules regarding the operation of your healthcare plan. IRS rules state that the choices made by a covered member during an open enrollment period must remain in effect for the entire plan year (January 1 through December 31). The only exception permitted under IRS rules is when a covered member has a **qualifying event**.

If you have a qualifying event, you may add, change, or discontinue healthcare coverage in a manner that is consistent with that qualifying event. Appropriate documentation that verifies the occurrence of the qualifying event must be presented to your campus Human Resources/Benefits Office before a change in healthcare plan coverage will be granted or approved. Some examples of qualifying events include:

- A change in your marital status;
- The birth or adoption of a child (including stepchildren and legally placed foster children) or placement for adoption;
- The death of a covered dependent;
- A change in the employment status of a covered member, his/her spouse, or his/her covered dependent(s) that affects eligibility for coverage under a cafeteria or other qualified healthcare plan;
- The loss of eligibility status by a covered dependent;
- A campus approved leave of absence without pay (maximum of 12 months);
- You and/or your spouse being called to full-time active military service/duty;
- Losing or gaining healthcare coverage eligibility under Medicare or Medicaid;
- A change in residence to a location outside of a healthcare plan's service area;
- Healthcare plan election choices made by spouses with different employers in which the employers have different healthcare plan years (*Please see the example below*); or

Change of Status Upon Attainment of Age 26

Your Comprehensive Care Healthcare Plan will provide coverage for your Dependent until the end of the month in which he/she attains age 26. For information regarding your Dependent's ability to continue healthcare coverage after age 26, please see "**Your COBRA Rights**."

Example:

You work for the University System of Georgia (USG) and have a January 1 – December 31 health benefits plan year. Your spouse works for XYZ employer. XYZ has an October 1 – September 30 health benefits plan year. **Both employer health benefits plans are qualified healthcare plans.**

You have “single” healthcare coverage with the University System of Georgia. Your spouse, employed by XYZ, discontinues his/her healthcare coverage with XYZ effective September 30. September 30 is the end of employer XYZ’s plan year. You wish to add your spouse, employed by XYZ, under your healthcare plan with the University System of Georgia, effective October 1. You request to make this change to avoid a break in healthcare coverage for your spouse.

Your spouse, employed by XYZ, conveys to XYZ that he/she will no longer participate in XYZ’s healthcare plan effective October 1. Under IRS regulations, the University System of Georgia may permit you to change your election from “single” to “employee + spouse” effective October 1. The spouse, employed by XYZ, must provide documentation/certification to the USG that he/she has lost healthcare coverage with XYZ within 30 days of qualifying event.

- The entry of a Qualified Medical Child Support Order (QMCSO)
A court-ordered qualified medical child support order (QMCSO) results from a divorce, legal separation, annulment, or change in legal custody. A QMCSO will require that you, your spouse, former spouse or other individual provide healthcare coverage for those enrolled dependent(s) that have been approved by the court. The court order and the effective date of healthcare plan coverage for those court-designated enrolled dependent(s) must be presented to your Human Resources/Benefits Office within 90 days of the court’s decision. If you are not enrolled in any level of coverage, the entry of a QMCSO will require that you enroll yourself as well as the child who is the subject of the QMCSO. There is not an option for child-only coverage.
- Children’s Health Insurance Program Reauthorization Act of 2009 (“CHIPRA”)
Under CHIPRA, if you or your spouse or Dependent (each, an “Eligible Individual”) loses coverage under Medicaid or the Children’s Health Insurance Program (“CHIP,” though it is known by other names in other states; Georgia’s, for example, is “PeachCare”) due to the loss of eligibility for such coverage, or becomes eligible for a premium subsidy under Medicaid or CHIP, the Employee may enroll in the Plan within 60 days of the loss of coverage or within 60 days of the date that eligibility for the subsidy is determined. In either case, coverage will become effective as of the date of enrollment and will not be retroactive. The loss of eligibility for premium assistance does not give rise to a right to change coverage, so it would not permit an Employee to drop subsidized coverage outside of an open enrollment period.

PLEASE NOTE:

For each of the qualifying events identified above, you must file a **timely** request with OneUSG Connect Benefits to add or to change healthcare coverage. For instances other than a qualified medical child support order (QMCSO) or a CHIPRA event, “**timely**” generally means **within 30 days of the event** that qualified you for a change in healthcare coverage (i.e., employment, loss of coverage, marriage, birth or adoption, etc.). A QMCSO must be presented to your Human Resources/Benefits Office within 90 days of issuance, however, and you have 60 days to provide notice of a CHIPRA event.

A failure to complete a change within these time limits will prohibit you from making such changes until the next University System open enrollment period. Unless the change is the addition of a new Dependent via birth, adoption or placement for adoption, the effective date for changes in healthcare coverage will be the first day of the month following the date of the receipt of the request for a change. If you acquire a new Dependent via birth, adoption or placement for adoption, however, and provide notice within 30 days, the enrollment of the new Dependent and of you, your Spouse and all eligible dependent children, if applicable, will be retroactive to the date of birth, adoption or placement for adoption.

To be "consistent with" the qualifying event, the change in your coverage generally must be only to add or drop coverage for the affected individual. For example, if you divorce, you may drop your former spouse from coverage but may not drop your own coverage. An important exception, however, is that if you acquire a new Dependent through birth, adoption or placement for adoption, you may enroll yourself, your Spouse and all eligible dependent children as well as the new dependent child.

CONTINUATION OF HEALTHCARE COVERAGE INTO RETIREMENT

A University System of Georgia Pre-65 retiree and/or Pre-65 dependents who, upon his/her separation from employment with the University System of Georgia, meets the criteria for retirement as set forth in Sections 8.2.8 and 8.2.9 (Retirement and Insurance) of The Board of Regents Policy Manual, may elect to continue healthcare plan coverage that he/she had immediately prior to retirement.

If you are a retiree or a dependent of a retiree and are turning age 65, your retiree health benefit will be provided in a different way. Medicare Part A and B will become your primary coverage. Your coverage through the USG group healthcare plan will end and you will enroll in supplemental healthcare coverage through the Aon Retiree Health Exchange. The USG retiree health benefit will be a contribution to a Health Reimbursement Account which may be used for reimbursement of monthly supplemental healthcare and/or prescription drug premiums and other eligible healthcare expenses.

If you are a retiree or a dependent of a retiree who is age 65 or older, but you're Pre-65 (non- Medicare Eligible) you will remain enrolled in the USG healthcare plan until you become age 65 and Medicare eligible. As you age in, you'll follow the steps above to enroll in the ARHE.

USG RETIREE OPEN ENROLLMENT PERIOD

for Pre-65 retirees and dependents

The USG retiree open enrollment period is generally held during the fall of each calendar year and will typically coincide with the open enrollment period for active Employees.

Medicare eligible retirees and dependents age 65 and older open enrollment period will coincide with the Medicare Open Enrollment period.

A retiree will not be permitted to participate in the open enrollment period unless he/she elected to take healthcare coverage into retirement at the time of his/her separation from employment with the University System of Georgia.

PRE-65 RETIREES

During a retiree open enrollment period, an eligible Pre-65 retired employee may elect to: (1) drop or discontinue healthcare coverage; (2) participate in a different healthcare plan option; and/or (3) reduce his/her level of coverage. During the open enrollment period, a Pre-65 retiree shall not be permitted to add healthcare coverage or increase the level of coverage that he/she took into retirement. See Qualifying Events below for permitted changes to a Pre-65 retiree's healthcare plan outside of the open enrollment period.

All eligible changes made during the open enrollment period will be effective as of the next January 1.

QUALIFYING EVENTS FOR CHANGES IN RETIREE HEALTHCARE PLAN COVERAGE

A USG retiree will be permitted to make a change in the level of USG healthcare coverage that he/she took into retirement if he/she has a qualifying event. The change in retiree healthcare coverage must be consistent with the qualifying event. A retiree will be required to provide the proper documentation to justify a requested benefits coverage change to OneUSG Connect Benefits. A retiree must request a coverage change within 30 days of the qualifying event.

Appropriate documentation, specific to the qualifying event, must be presented to OneUSG Connect-Benefits before a change in healthcare plan coverage will be granted or approved.

There are only five qualifying events that a University System of Georgia institution may consider in granting a change in the level of healthcare coverage for a USG Pre-65 retiree who is enrolled in one of our healthcare plans. Please note: These qualifying events do not apply to retirees who did not continue healthcare coverage into retirement. **As a USG retiree, if you do not continue a USG healthcare plan into retirement – or you decide to end your USG healthcare plan coverage at any point after you retire – you will not be eligible to re-enroll in a USG healthcare plan at any point in the future.** They are:

1. Becoming eligible for Medicare due to a disability;
2. The addition of a dependent(s) because of marriage, birth, adoption or a Qualified Medical Child Support Order (QMCSO);
3. The loss of a dependent's health benefit coverage through a change in a spouse's group coverage, through COBRA coverage, through Medicare, or through Medicaid;
4. A change in a spouse's employment status that affects coverage eligibility under a qualified health plan; and
5. A CHIPRA event described below.

A Qualified Medical Child Support Order (QMCSO) is a court-ordered remedy resulting from a divorce, legal separation, annulment, or change in legal custody. A QMCSO requires that an individual provide healthcare coverage for an enrolled dependent(s) that has been approved by the court. The court order and effective date of healthcare plan coverage for a court-designated enrolled dependent(s) must be presented to OneUSG Connect Benefits, within 90 days of the court's decision.

You also may make a change in your level of coverage if your spouse or Dependent experiences a "CHIPRA" event. "CHIPRA" is the Children's Health Insurance Program Reauthorization Act of 2009. Under CHIPRA, if your spouse or Dependent (each, an "Eligible Individual") loses coverage under Medicaid or the Children's Health Insurance Program ("CHIP," though it is known by other names in other states; Georgia's, for example, is "PeachCare") due to the loss of eligibility for such coverage, or becomes eligible for a premium subsidy under Medicaid or CHIP, the Employee may enroll the spouse or Dependent in the Plan within 60 days of the loss of coverage or within 60 days of the date that eligibility for the subsidy is determined. In either case, coverage will become effective as of the date of enrollment and will not be retroactive. The loss of eligibility for premium assistance does not give rise to a right to change coverage, so it would not permit an Employee to drop subsidized coverage outside of an open enrollment period.

PLEASE NOTE:

For each of the qualifying events that are identified above, one must file a timely request with OneUSG Connect-Benefits. For instances other than a qualified medical child support order (QMCSO), “timely” means within 30 days of the qualifying event. A QMCSO must be presented to the appropriate Human Resources/Benefits Office within 90 days of issuance. You have 60 days to request special enrollment after a CHIPRA event. If you acquire a new Dependent via birth, adoption or placement for adoption and provide notice within 30 days, the enrollment of the new Dependent will be retroactive to the date of birth, adoption or placement for adoption. Otherwise, the new enrollments are effective as of the first day of the month following your providing notice of the event.

A failure to complete a change within 30 (or 60 or 90, as applicable) days of a qualifying event will prohibit one from making such changes. Unless otherwise noted, the effective date for changes in healthcare coverage will be the first day of the month following the date of the receipt of the requested change.

PERMISSIBLE USG RETIREE HEALTHCARE PLAN CHANGES

Please be reminded that retiree healthcare premiums ***are not paid with pre-tax dollars***. Therefore, a retiree may reduce or discontinue his/her healthcare coverage at any time during the plan year. If you wish to reduce or discontinue your healthcare coverage, please contact OneUSG Connect-Benefits to initiate your change.

If you reduce your level of healthcare coverage, you *will not be permitted* to increase your coverage at a later date without establishing one of the qualifying events described above. ***As a retiree, if you elect to discontinue your healthcare coverage, you will not be permitted to re-enroll at a later date.***

Important Note: 1. Effective July 1, 2015, all Pre-65 Medicare eligible retirees and dependents will have supplemental only coverage through USG Healthcare Plans. 2. If when you retire, your spouse has coverage outside of USG, you are allowed to request a qualifying life event to add your spouse to your retiree insurance at a later date and provide supporting documents.

HOW YOUR BENEFITS WORK FOR YOU

Introduction

If you have any questions about anything in this Benefit Booklet, please call the member service number located on the back of your Identification (ID) Card.

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

In-Network Services

A Member has access to primary and some specialty care directly from any In-Network Physician. A Primary Care Physicians / Providers (PCP) Referral is not needed.

When you use an In-Network Provider or get care as part of an Authorized Service (an "Authorized Service" is a special case in which an Out-of-Network Provider will be paid as an In-Network Provider), Covered Services will be covered at the In-Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service.

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

To see a Doctor, call their office:

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

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

For services from In- Network Providers:

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

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

Out-of-Network Services

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

For services from an Out-of-Network Provider:

1. The Out-of-Network Provider can charge you the difference between their bill and the Plan's Maximum Allowed Amount (this is "Balance Billing"), plus any Deductible, Coinsurance or Copayments unless your claim involves a Surprise Billing Claim. Thus, you may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and Copayments). *A determination that Covered Services are Medically Necessary, or even precertification, do not prevent an Out-of-Network Provider from Balance Billing.*
2. You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments) unless your claim involves a Surprise Billing Claim;
3. You will have to pay for services that are not Medically Necessary.
4. You will have to pay for non-Covered Services.
5. You may have to file claims.
6. You must make sure any necessary Pre-certification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

There are two ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located, details about their education, and other information that confirms they are the right fit for your care need.

1. Register with the Accolade App or Portal (member.accolade.com) and access the **Find Care** feature. This tool allows you to search for Doctors, Providers, and Facilities that participate in your Plan's network and fit your preferences such as geographic area.
2. Call Accolade at 866-204-9818 for help finding Doctors or Providers that participate in this Plan's network. An Accolade Health Assistant will also work to ensure the provider has relevant experience for your care need, is the right specialty, and fits other preferences such as geographic area.

What's Covered

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

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

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

Allergy Services

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

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

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

For ground ambulance, you are taken:

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

For air or water ambulance, you are taken:

- From the scene of an accident or medical Emergency to a Hospital;
- Between Hospitals, including when the Claims Administrator requires you to move from an Out-of-Network Hospital to an In-Network Hospital as a condition of the hospitalization's being covered under this Plan; or
- Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews.

Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. An Out-of-Network Provider, however, may still balance-bill for the difference between the amount billed and the amount this Plan will cover, unless it is a Surprise Billing Claim. A Medical Necessity determination, or even precertification, does not prevent Balance Billing.

Non-Emergency ambulance services are subject to Medical Necessity reviews. When using an air ambulance for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider selected, no benefits will be available. Please note that an Out-of-Network Provider may bill you for any charges that exceed the Maximum Allowed Amount, unless the bill is for a Surprise Billing Claim. Please see the "Schedule of Benefits" for the maximum benefit.

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

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

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

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Autism Services Applied Behavior Analysis (ABA)

Your Plan includes coverage for the treatment of neurological deficit disorders.

Autism Services

Your Plan includes coverage for the treatment of neurological deficit disorders, including autism. Your Plan also covers certain treatments associated with autism spectrum disorder (ASD). Coverage for ASD includes but is not limited to the following:

- Diagnosis of autism spectrum disorder;
- Treatment of autism spectrum disorder;
- Pharmacy care;
- Psychiatric care;
- Psychological care; and
- Therapeutic care

Members must use a licensed provider, or a board certified behavioral analyst to be eligible for benefits under the plan. Prior Authorization is required before benefits will be approved.

Behavioral Health Services

The Claims Administrator provides a network of healthcare professionals and hospitals. Licensed healthcare professionals are available 24 hours a day, 7 days a week, to provide referrals for mental health and substance abuse treatment.

Please Note: To access information regarding Member benefits or Precertification, please call the appropriate number located on the back of your identification card.

Inpatient Care (Behavioral Health)

If a Member is admitted to an In-Network Hospital or Facility, the Claims Administrator will authorize an initial number of days of treatment. During the Member's stay in the Hospital, the Claims Administrator will review the Member's treatment plan with his/her attending physician and with his/her Hospital. The Claims Administrator may authorize additional Hospital or Facility days if the Member's treatment is deemed to be Medically Necessary. The criteria for establishing Medical Necessity will be determined by Anthem.

- In-Network Facility Charges:

The plan will pay 90% of the network rate; subject to deductible. Pre-certification is required.

- In-Network Provider Charges:

The plan will pay 90% of the network rate; subject to deductible. Pre-certification is required.

Mental health and substance abuse treatment services must be medically necessary and must be provided by a qualified professional. A qualified professional is a licensed Psychiatrist (MD); a licensed Clinical Psychologist (Ph.D.); a licensed Clinical Social Worker (LCSW); a licensed Professional Counselor (LPC); a licensed Marriage and Family Therapist (LMFT); and/or a Masters-level RN (Clinical Nurse Specialist).

Expenses That The Mental Health and Substance Abuse Treatment Plan does not Cover.

Some treatment/services that are not covered by the *Mental Health and Substance Abuse Program* include, but are not limited, to:

- Hypnotherapy;
- Child care, social adjustment, financial, pastoral or marriage counseling;
- Psychological testing unrelated to a behavioral diagnosis;
- Treatment for attention deficit disorder (ADD) or attention deficit hyper-disorder (ADHD) therapy (except diagnosis and medical management), learning disabilities, developmental delays, or speech disorders;
- Educational examinations or neurolinguistical programming;
- Court-ordered mental health and substance abuse treatment unless medical necessity is certified by Anthem;
- Situational counseling other than for brief visit therapy;
- Vocational or education training/services; and
- Treatment of a condition that arises from mental retardation, academic skills disorder, developmental disorder, or motor skills disorder.

Cardiac Rehabilitation

Please see “Therapy Services” later in this section.

Chemotherapy

Please see “Therapy Services” later in this section.

Chiropractic Services

Benefits are available for chiropractic treatments provided by a Doctor of Chiropractic when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations, and treatment.

Cochlear Implants

Services for Cochlear implants. The batteries for Cochlear Implant devices are not a covered expense. Pre- authorization is required.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

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

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions (this does not include the surgical extraction of partially erupted teeth or impacted wisdom teeth)
- Anesthesia

Treatment of Accidental Injury

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

Other Dental Services

Hospital or Facility charges and anesthesia needed for dental care are covered if the Member meets any of the following conditions:

- The Member is under the age of 7;
- The Member has a chronic disability that is attributable to a mental and/ or physical impairment which results in substantial functional limitation in an area of the Member's major life activity, and the disability is likely to continue indefinitely; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Pre-certification required for all dental services.

Diabetes Equipment, Education, and Supplies

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a health care professional who is licensed, registered, or certified under state law.

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

For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this section.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include, but are not limited to, the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

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

Advanced Imaging Services

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

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

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

Dialysis

See “Therapy Services” later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment (DME), Medical Devices and Supplies

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

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

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

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

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Your Plan includes benefits for prosthetics and durable medical equipment and medical supplies for the treatment of diabetes. Your plan also includes benefits for breast pumps as described in the "Preventive Care" section.

Orthotics

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

Prosthetics

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

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

- Artificial limbs and accessories;
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act; or
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Wigs needed after cancer treatment and alopecia areata.

Emergency Care Services

Emergency Services

Benefits are available in a Hospital Emergency Room or freestanding Emergency Facility for services and supplies to treat the onset of symptoms for an Emergency.

Emergency Care

“Emergency Care” means a medical exam done in the Emergency Department of a Hospital, or freestanding Emergency Facility and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to stabilize the patient.

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

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as you are stabilized. We will review your care to decide if a Hospital stay will be covered and how many days stay will be covered. See “Getting Approval for Benefits” for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Providers Licensed or Otherwise Authorized in Georgia

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. The Out-of-Network Provider can only charge you any applicable Deductible, Coinsurance, and/or Copayment and cannot bill you for the difference between the Maximum Allowed Amount and their billed charges until your condition is stable. Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover them as an Authorized Service. Your cost shares will be based on the Maximum Allowed Amount and will be applied to your In-Network Deductible and In-Network Out-of-Pocket Limit.

If the Out of Network Provider is licensed or otherwise authorized in the state of Georgia to render Emergency Care, we will pay the Out-of-Network Provider the Maximum Allowed Amount for the Emergency Care which shall be the greater of the following:

1. The most recent amount negotiated by us with the Out-of-Network Provider for the Emergency Care during which time the Provider was an In-Network Provider;
2. The median contracted rate as determined by the state;
3. Any other amount as determined by us given the complexity of the services rendered.

The Out-of-Network Provider may not bill you for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount.

Providers Not Licensed or Otherwise Authorized in Georgia

If the Out-of-Network Provider is not licensed or otherwise authorized in the State of Georgia to render Emergency Care the Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider

will be determined using the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided.

Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. 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 will be applied to your In-Network Out-of-Pocket Limit.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay will be covered and how many days stay will be covered. See “Getting Approval for Benefits” for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover them as an Authorized Service.

Gene Therapy

Your Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification. See “Getting Approval for Benefits” for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for certain gene therapy services.

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

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

Hearing Aids for Children (18 years old and under)

“Hearing Aid” means any non-experimental and wearable instrument or device offered to aid or compensate for impaired human hearing that is worn in or on the body. The term “hearing aid” includes any parts, ear molds, repair parts, and replacement parts of such instrument or device, including, but not limited to, non-implanted bone anchored hearing aids, non-implanted bone conduction hearing aids, and frequency modulation systems. Personal sound simplification products shall not qualify as hearing aids.

Coverage shall be one hearing aid per hearing impaired ear not to exceed \$3,000.00 per hearing aid for covered dependents 18 years old or under. Coverage shall provide the replacement for one hearing aid per hearing impaired ear every 48 months for eligible covered dependents.

Coverage provided shall include the following:

Medically necessary services and supplies, including the initial hearing aid evaluation, fitting, dispensing, programming, batteries, cords, servicing, repairs, follow-up maintenance, adjustments, ear molds, ear mold impressions, auditory training, and probe microphone measurements to ensure appropriate gain and output, as well as verifying benefit from the system selected according

to accepted professional standards. Such services shall be covered on a continuous basis, as needed, during each 48 month coverage period not to exceed \$3,000.00 per hearing impaired ear or for the duration of the hearing aid warranty, whichever time period is longer.

Home Care Services

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

Covered Services include but are not limited to:

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

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

Hospice Care

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

Covered Services include:

- Care from an interdisciplinary team care with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services from a licensed social worker.
- Nutritional support, such as intravenous feeding and feeding tubes.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.

- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.

Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties, for one year after the Member's death. The Doctor must agree to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

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

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

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

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

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

Covered Transplant Procedure

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

Centers of Excellence (COE) Transplant Providers

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

In-Network Transplant Provider

A Provider that we have chosen and designated as a Centers of Medical Excellence for Transplant and/or Blue Distinction Centers + or Blue Distinction Centers for Transplant. A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. The Provider has entered into a Transplant

Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

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

Out-of-Network Transplant Provider

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

Prior Approval and Precertification

To maximize your benefits, you should call the Customer Service phone number on the back of your Identification Card and speak with an Accolade Health Assistant as soon as you think you may need a transplant to talk about your benefit options. They will help you maximize your benefits by giving you coverage information, including details on what is covered and connect to an Accolade Nurse to understand any clinical coverage guidelines, medical policies, or Exclusions that may apply.

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

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

Donor Benefits

Benefits for an organ donor are as follows:

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

Transportation and Lodging

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

to the Claims Administrator when claims are filed. Call the Claims Administrator for complete information.

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

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

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Claims Administrator,
- Administrator,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related to, or a direct result of, the transplant,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Certain Human Organ and Tissue Transplant Services may be limited.

Infertility Services

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

Infusion Therapy

See “Therapy Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for a private room is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.

- A room in a special care unit approved by the Claims Administrator. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include, but not limited to:

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

Maternity and Reproductive Health Services

Maternity

Maternity Global Coverage – Maternity services are paid through global reimbursement. This reimbursement process allows a provider to only file once for all levels of maternity care (prenatal, delivery and post-natal). A Copay will apply for the initial office visit. Any subsequent care following the initial visit for the remainder of the pregnancy will pay at 100% for the delivering doctor. If the mother changes her doctor mid-pregnancy, the global benefits will not apply towards the former doctor, but only the delivering doctor. The former doctor would file all services they rendered, as global reimbursement will no longer apply, and all claims would be subject to their applicable Copay.

Covered maternity services include, but are not limited to:

- Professional and Facility services for childbirth in a Facility or the home (see Definitions for Professional and Facility Services), including the services of an appropriately licensed nurse midwife;

- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services; and
- Medically Necessary fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed.

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

Contraceptive Benefits

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

Sterilization Services

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

Infertility Services

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

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

Nutritional Counseling

Covered Services include nutritional counseling visits when referred by your Doctor.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office and Home Visits

Covered Services include:

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

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

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

Retail Health Clinic Care for limited basic health care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or nurse practitioners. Services are limited to routine care and the treatment of common illnesses for adults and children.

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

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

LiveHealth Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online care visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions. For Mental Health and Substance Abuse on-line Visits, see the “Mental Health and Substance Abuse” section.

Orthotics

Please refer to the “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies” earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Center,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by the Claims Administrator.

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

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

- Diagnostic services, and
- Therapy services.

Physical Therapy

Please see “Therapy Services” later in this section.

Preventive Care

Preventive Care is given during an office visit or as an outpatient. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the “Diagnostic Services” benefit, not this benefit.

Preventive care services will meet the requirements of federal and state law. Many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider. That means the Plan covers 100% of the Maximum Allowed Amount. Covered Services fall under the following broad groups:

- Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples include screenings for:
 - Breast cancer,
 - Cervical cancer,
 - Colorectal cancer,
 - High blood pressure,
 - Type 2 Diabetes Mellitus,
 - Cholesterol, and
 - Child and adult obesity.
- Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
- Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - Women’s contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered.
 - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.
 - Gestational diabetes screening.
- Preventive care services for tobacco cessation for members age 18 and older as recommended by the United States Preventive Services Task Force including:
 - Counseling

- Prescription Drugs
- Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

Prescription Drugs and OTC items are limited to a no more than 180-day supply per 365 days.

- Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
 - Aspirin
 - Folic acid supplement
 - Iron supplement
 - Bowel preparations

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

You may call Customer Service at the number on your Identification Card for more details about these services or view the federal government's web sites:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

<http://www.ahrq.gov>, and

<http://www.cdc.gov/vaccines/acip/index.html>.

Covered Services also include the following services required by state and federal law:

- Lead poisoning screening for children.
- Routine mammograms.
- Appropriate and necessary childhood immunizations that meet the standards approved by the U.S. public health service for such biological products against at least all of the following:
 - Diphtheria,
 - Pertussis,
 - Tetanus,
 - Polio,
 - Measles,
 - Mumps,
 - Rubella,
 - Hemophilus influenza b (Hib),
 - Hepatitis B, and
 - Varicella (shingles).

(Additional immunizations will be covered per federal law, as indicated earlier in this section.)

- Routine colorectal cancer examination and related laboratory tests.
- Chlamydia screening.
- Ovarian surveillance testing.
- Pap smear.
- Prostate screening.

Prosthetics

Please refer to “Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

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

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

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

Habilitative Services

Benefits also include habilitative services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

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

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

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

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

Oral Surgery

Important Note: Although this Plan provides coverage for certain oral surgeries, many types of oral surgery procedures are not covered by this medical Plan.

Benefits are also limited to certain oral surgeries including:

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

Reconstructive Surgery

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

Mastectomy Notice

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

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

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

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

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

Therapy Services

Physical Medicine Therapy Services

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

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness or injury. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services in any setting.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

Early Intervention Services

Physical, Occupational and Speech Therapy

Benefits are available for the care and treatment of congenital defects and birth abnormalities for covered children without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. From the Member's birth until the Member's third (3rd) birthday, these early intervention services shall be provided only to the extent required by law. From the Member's birth until the Member's sixth (6th) birthday, benefits are allowed up to the maximum visits listed in the "Benefit at a Glance" for physical, speech and occupational therapies.

For all other Members (e.g., those six (6) and older, or who not qualify for the benefits above), benefits are provided only if the physical, speech or occupational therapy will result in a practical improvement in the level of functioning within a reasonable period of time and is Medically Necessary. Benefits for physical, speech or occupational are allowed up to the maximum visits listed in the “Benefit at a Glance.”

Other Therapy Services

Benefits are also available for:

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

Transplant Services

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

Urgent Care Services

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

Benefits for urgent care include:

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

Virtual Visits (Telemedicine / Telehealth Visits)

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

- “Telemedicine / Telehealth” means the delivery of health care or other health services using electronic communications and information technology. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

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

Vision Services (All Members / All Ages)

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

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

Prescription Drugs Administered by a Medical Provider

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

Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by this portion of the Plan. Instead, refer to the "Pharmacy Benefit Manager (PBM) Program" section below or additional materials provided by CVS/Caremark, or call CVS/Caremark at the number shown under the "Resource Contacts" section of this Benefit Booklet.

Important Details about Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs administered by a Provider should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before the Claims Administrator can decide if the drug is Medically Necessary. The Claims Administrator may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of its Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Covered Prescription Drugs

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

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

Prior Authorization

Prior Authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. The Claims Administrator will contact your Provider to get the details needed to decide if Prior Authorization should be given. The Claims Administrator will give the results of its decision to both you and your Provider.

If Prior Authorization is denied you have the right to file an Appeal (Grievance) as outlined in the "Your Right to Appeal" section of this Benefit Booklet.

For a list of Prescription Drugs that need prior authorization, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with the Claims Administrator to verify drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Plan.

Step Therapy

Step therapy is a process in which you may need to use one type of drug before the Plan will cover another. The Claims Administrator checks certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain drug is needed, then Prior Authorization will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. The Claims Administrator may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. The Claims Administrator has a therapeutic drug substitutes list which is reviewed and updated from time to time. For questions or issues about therapeutic drug substitutes, call Customer Service at the phone number on the back of your Identification Card.

What's Not Covered

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

1. **Acts of War, Disasters, or Nuclear Accidents** - In the event of a major disaster, epidemic, war, or other event beyond the Claims Administrator's control, the Claims Administrator will make a good faith effort to give you Covered Services. The Claims Administrator will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.
Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience. This exclusion does not apply to acts of terrorism.
2. **Administrative Charges**
 - a. Charges for the completion of claim forms,
 - b. Charges to get medical records or reports,
 - c. Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
3. **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
4. **Alternative / Complementary Medicine** - Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
 - a. Acupuncture,
 - b. Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body,
 - c. Holistic medicine,
 - d. Homeopathic medicine,
 - e. Hypnosis,
 - f. Aroma therapy,
 - g. Massage and massage therapy,
 - h. Reiki therapy,
 - i. Herbal, vitamin or dietary products or therapies,
 - j. Naturopathy,
 - k. Thermography,
 - l. Orthomolecular therapy,
 - m. Contact reflex analysis,
 - n. Bioenergetic synchronization technique (BEST),
 - o. Iridology-study of the iris,
 - p. Auditory integration therapy (AIT),
 - q. Colonic irrigation,
 - r. Magnetic innervation therapy,
 - s. Electromagnetic therapy, or
 - t. Neurofeedback / Biofeedback.
5. **Autopsies** Autopsies and post-mortem testing.

6. **Before Effective Date or After Termination Date** - Charges for care you get before your coverage is in effect or after your coverage ends.
7. **Certain Providers** - Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples include, but are not limited to, masseurs
or masseuses (massage therapists), physical therapist technicians, and athletic trainers.
8. **Charges Over the Maximum Allowed Amount** - Charges over the Maximum Allowed Amount for Covered Services, except for Surprise Billing Claims as outlined in the "Surprise Bill Legislation Notice" section in the front of this Booklet .
9. **Charges Not Supported by Medical Records** - Charges for services not described in your medical records.
10. **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments, unless coverage is required to comply with Section 2709 of the Public Health Service Act (PHSA).
11. **Complications of Non-Covered Services** - Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non- Covered Service and would not have taken place without the non-Covered Service. This Exclusion does not apply to problems resulting from pregnancy.
12. **Contraceptives** - Non-prescription contraceptive devices unless required by law.
13. **Cosmetic Services** - Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).
This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, or surgery to restore function of any body area that has been altered by illness or trauma.
14. **Court-Ordered Testing** - Court-ordered testing or care unless Medically Necessary.
15. **Crime** - Treatment of injury or illness that results from a crime you committed or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
16. **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
17. **Custodial Care** - Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
18. **Dental Treatment** - Dental treatment, except as listed below.
Excluded dental treatment includes but is not limited to preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment for the teeth, jaw or gums such as:
 - Removing, restoring, or replacing teeth;
 - Medical care or surgery for dental problems (unless listed as a Covered Service in this Benefit Booklet);
 - Services to help dental clinical outcomes.
 - Dental devices for snoring
 - Removal of impacted wisdom teeth
 - Dental treatment for injuries that are a result of biting or chewing is also excluded,

unless the chewing or biting results from a medical or mental condition. This exclusion does not apply to services that must be covered by law.

19. **Dental Services** – Dental services not described as Covered Services in this Benefit Booklet.
20. **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based. **Experimental or Investigational Services** - Services or supplies that are found to be Experimental or Investigational. This also applies to services related to Experimental or Investigational services, whether you get them before, during, or after you get the Experimental or Investigational service or supply.

The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if the Claims Administrator deems it to be Experimental or Investigational.
21. **Eyeglasses and Contact Lenses** - Eyeglasses and contact lenses to correct your eyesight.

This Exclusion does not apply to lenses needed after a covered eye surgery.
22. **Eye Exercises** - Orthoptics and vision therapy.
23. **Eye Surgery** - Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.
24. **Family Members** - Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
25. **Foot Care** - Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses, trimming nails, cleaning and preventive foot care including, but not limited to:
 - a. Cleaning and soaking the feet.
 - b. Applying skin creams to care for skin tone.
 - c. Other services that are given when there is not an illness, injury or symptom involving the foot.
26. **Foot Orthotics** - Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.
27. **Foot Surgery** - Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
28. **Fraud, Waste, Abuse, and Other Inappropriate Billing Services from an Out-of-Network Provider** that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.
29. **Free Care** - Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from freeclinics.

If your group is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.
30. **Hearing Aids** - Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Benefit Booklet. This Exclusion does not apply to cochlear implants.
31. **Health Club Memberships and Fitness Services** - Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Provider. This Exclusion also applies to health spas.

32. **Home Care**
 - a. Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a home health care Provider.
 - b. Private duty nursing.
 - c. Food, housing, homemaker services and home delivered meals.
33. **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.
34. **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).
35. **Infertility Treatment** - Testing or treatment related to infertility except for diagnostic services and procedures to correct an underlying medical condition. Infertility procedures not specified in this Benefit Booklet.
36. **Maintenance Therapy** - Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function but does not result in any change for the better.
37. **Medical Equipment and Supplies**
 - a. Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - b. Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c. Non-Medically Necessary enhancements to standard equipment and devices.
 - d. Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.
38. Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "What's Covered" section.
39. **Medicare** For which benefits are payable under Medicare Parts A or B or would have been payable if you had applied for Parts A or B, except, as listed in this Benefit Booklet or as required by federal law, as described in the section titled "Medicare" in the "General Provisions" section. For the purposes of the calculation of benefits, where Medicare should be the primary payor, if you do not enroll in Medicare Part B, when you are eligible, the Claims Administrator will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
40. **Missed or Cancelled Appointments** - Charges for missed or cancelled appointments.
41. **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility
42. **Non-Covered Behavioral Health Services** - Services for outpatient therapy or rehabilitation unless listed as Covered Service in this Benefit Booklet.
43. **Non-Medically Necessary Services** - Services the Claims Administrator concludes are not Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
44. **Nutritional or Dietary Supplements** - Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that must be covered by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.
45. **Oral Surgery** - Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat

- the teeth or bones and gums directly supporting the teeth, except as listed in this Benefit Booklet.
46. **Outpatient Therapy or Rehabilitation** - Services for outpatient therapy or rehabilitation unless listed as a Covered Service in this Benefit Booklet.
 47. **Personal Care and Convenience**
 - a. Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs;
 - b. First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads);
 - c. Home workout or therapy equipment, including treadmills and home gyms;
 - d. Pools, whirlpools, spas, or hydrotherapy equipment;
 - e. Hypo-allergenic pillows, mattresses, or waterbeds; or
 - f. Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
 - g. Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
 48. **Private Duty Nursing** - Private Duty Nursing Services.
 49. **Prosthetics** - Prosthetics for sports or cosmetic purposes.
 50. **Providers** - Services you get from a non-covered provider, as defined in this Benefit Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.
 51. **Residential Accommodations** Residential Accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, service, supplies or charges for the following.
 - a. Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included
 - b. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - c. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included
 52. **Routine Physical Exams** - Physical exams required for enrollment in any insurance program, as a condition of employment, for licensing, or for school activities.
 53. **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that Anthem determines require in-person contact and/or equipment that cannot be provided remotely.
 54. **Sexual Dysfunction** - Services or supplies for male or female sexual problems. (except male organic erectile dysfunction).
 55. **Stand-By Charges** - Stand-by charges of a Doctor or other Provider.
 56. **Sterilization** - Reversals of elective sterilizations are not covered. This does not apply to sterilizations for women, which will be covered under the "Preventive Care" benefit. Please see that section for further details.
 57. **Surrogate Mother Services** - Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

58. **Travel Costs** - Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
59. **Vein Treatment** - Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
60. **Vision Services** - Vision services not described as Covered Services in this Benefit Booklet.
61. **Waived Cost-shares Out-of-Network** - For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
62. **Weight Loss Programs** - Programs, whether or not under medical supervision, unless listed as covered in this Benefit Booklet.
This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
63. **Weight Loss Surgery** - Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.
64. **Wilderness or other outdoor camps and/or programs.**

Claims Payment

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

In order to assist you in understanding the Maximum Allowed Amount language as described below, please refer to the definition of In-Network Provider, Out-of-Network Provider and Non-Preferred Provider contained in the Definitions section of this Benefit Booklet.

Maximum Allowed Amount

General

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-network Providers is based on this/your Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see "Out-of-Network Services" later in this section for additional information.

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

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

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

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

When you receive Covered Services from an eligible Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowed Amount. The application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistently with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other healthcare

professional, the Maximum Allowed Amounts may be reduced for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

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

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

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-network Provider (with the exception of Emergency Care and/or services resulting from a Surprise Billing Claim), the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

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

For services provided by an Out-of-Network Provider licensed or otherwise authorized in the state of GA resulting in a Surprise Billing Claim, we will pay the Out-of-Network Provider the Maximum Allowed Amount which shall be the greater of the following:

1. The most recent amount negotiated by us with the Out-of-Network Provider for the Covered Service

- during which time the Provider was an In-Network Provider;
2. The median contracted rate as determined by the state;
 3. Any other amount as determined by us given the complexity of the services rendered.

If the Out-of-Network Provider is not licensed or otherwise authorized in the State of Georgia the Maximum Allowed Amount from an Out-of-Network Provider will be determined using the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided.

The Out-of-Network Provider may not bill you for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount.

Providers who are not contracted for this product but are contracted for the Claims Administrator's indemnity product are considered Non-Preferred. For this/your plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount. In this case, Non-Preferred Providers may not send you a bill and collect for the amount of the Non-Preferred Provider's charge that exceeds the Maximum Allowed Amount for Covered Services.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount unless your claim involves a Surprise Billing Claim. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges unless such charges are the result of Emergency Care and/or a Surprise Billing Claim. This amount can be significant. Choosing an In-Network provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding an In-Network Provider or call the number on the back of your ID card to verify Provider Network status for Providers who may render Covered Services to you including, but not limited to, radiologists, anesthesiologists, pathologists, or emergency medicine physicians.

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

Member Cost Share

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

Your cost share amount and out-of-pocket limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network or Non-Preferred Providers. Please see the "Benefit at A Glance" section in this Benefit Booklet for your cost share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or cost share amounts may vary by the type of Provider you use.

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

In some instances, you may only be asked to pay the lower In-Network cost sharing amount when you use

an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge unless such charges are the result of a Surprise Billing Claim. Note that we will not deny or restrict Covered Services provided by the In-Network Provider solely on the basis that you obtained services from an Out-of-Network Provider.

If you request a referral to an Out of Network Provider for additional Covered Services while receiving a Covered Service at an In-Network Facility, such additional Covered Services shall not be considered a Surprise Bill if the provider has followed the notice and consent requirements set forth in the in the "Surprise Bill Legislation Notice" section. This requirement does not apply to Ancillary Services.

Authorized Services

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

Claims Review

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

Notice of Claim & Proof of Loss

After you get Covered Services, the Claims Administrator must receive written notice of your claim within 12 months in order for benefits to be paid. The claim must have the information needed to determine benefits. If the claim does not include enough information, the Claims Administrator will ask for more details and it must be sent in order for benefits to be paid, except as required by law. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information.

In certain cases, you may have some extra time to file a claim. If the Claims Administrator did not get your claim within 12 months, but it is sent in as soon as reasonably possible and within one year after the 12-month period ends (i.e., within 24 months), you may still be able to get benefits. **However, any claims, or additional information on claims sent in more than 24 months after you get Covered Services will be denied, unless an extension is required by federal law.**

Claim Forms

Contact your campus Human Resources Benefits Office or Customer Service and ask for a claim form to be sent to you. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

Member's Cooperation

You will be expected to complete and submit to the Plan all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate (including if you fail to enroll under Part B of the Medicare program where Medicare is the responsible payer), you will be responsible for any charge for services that would have been paid or reimbursed by such a program.

Payment of Benefits

The Claims Administrator may make benefit payments directly to In-Network Providers for Covered Services. If you use an Out-of-Network Provider, however, the Claims Administrator may make benefit payments to you or the Out-of-Network provider, at the Claims Administrator's discretion.

Payments may also be made to and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMCSO), as having a right to enrollment under the Plan), or that person's custodial parent or designated representative. Any benefit payments made will discharge the Plan's obligation to pay for Covered Services. You cannot assign your right to benefits to anyone else, except as required by a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.

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

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee based on claims processed. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you, with respect to claims under your plan.

Inter-Plan Programs

Out of Area services

Blue Cross Blue Shield Health Plan has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Blue Cross Blue Shield Health Care service area, the claims for these services may be processed through

one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Blue Cross Blue Shield Health Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Blue Cross Blue Shield Health Plan service area, you will obtain care from Providers that have a contractual agreement (i.e., are “participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from nonparticipating healthcare Providers Blue Cross Blue Shield Health Plan payment practices in both instances are described below.

Blue Cross Blue Shield Health Plan covers only limited healthcare services received outside of Blue Cross Blue Shield Health Plan corporate parent’s service area. As used in this section, “Out-of-Area Covered Healthcare Services” include Emergency and Urgent Care obtained outside the geographic area Blue Cross Blue Shield Health Plan corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Blue Cross Blue Shield Health Plan will remain responsible for fulfilling Blue Cross Blue Shield Health Plan contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you access covered healthcare services outside Blue Cross Blue Shield Health Plan service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Blue Cross Blue Shield Health Plan.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Blue Cross Blue Shield Health Plan uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, your liability for any covered healthcare services would then be calculated according to applicable law. For information on states that participate in this program, go to https://www.Anthem.com/shared/noapplication/memberservices/nosecondary/notertiary/pw_a113425.pdf.

You will be entitled to benefits for healthcare services that you accessed either inside or outside the geographic area Blue Cross Blue Shield Health Plan serves, if this Plan covers those healthcare services. Due to variations in Host Blue network protocols, you may also be entitled to benefits for some healthcare services obtained outside the geographic area Blue Cross Blue Shield Health Plan serves, even though you might not otherwise have been entitled to benefits if you had received those healthcare services inside the geographic area Blue Cross Blue Shield Health Plan serves. But in no event will you be entitled to benefits for healthcare services, wherever you received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Plan.

Non-Participating Healthcare Providers Outside The Claims Administrator's Service Area

Member Liability Calculation

When covered healthcare services are provided outside of the Claims Administrator's Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph.

Exceptions

In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Plan would make if the healthcare services had been obtained within the Claims Administrator's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Plan will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Surprise Bill Claims will be administered as set forth in the Surprise Billing Legislative Notice at the front of this document.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered non-network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Customer Service number on your ID card or go to www.Anthem.com/usg for more information about such arrangements.

Getting Approval for Benefits

Your Plan includes the processes of Pre-certification, Predetermination and Post Service Clinical Claims Reviews to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service where they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Types of Requests

- **Prior Authorization** – Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The Claims Administrator may decide a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more costeffective.
- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Provider must tell the Claims Administrator within 48 hours of the admission. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. The Claims Administrator will check your Plan to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Plan or is Experimental or Investigational as that term is defined in this Plan.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental or Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

The Provider should contact the Claims Administrator to request a Precertification or Predetermination review. The Claims Administrator will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

The Claims Administrator will use clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines, and other applicable policies to help make Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

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

The Claims Administrator may, from time to time, waive, enhance, change or end certain medical

management processes (including utilization management, case management, and disease management) if in the Claims Administrator's discretion, such change furthers the provision of cost effective, value based and/or quality services.

Request Categories

- **Urgent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.
- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** - A request for Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Reviewing Where Services Are Provided

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

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

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

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

Eligibility

A Member receiving benefits under an alternative benefit plan may, at any time, elect to discontinue the plan and revert to regular Plan benefits.

The Claims Administrator is responsible for determining eligibility for cases to be included in the program.

The Member—or legal guardian or family member, if applicable—and the attending Physician must consent to explore with the Claims Administrator the possibilities of transfer to an alternative treatment setting and, prior to implementation, agree to the alternative benefit plan.

Benefits

Benefits will be determined on a case-specific basis, depending on the plan of treatment, and may include Covered Services under the applicable Plan.

Services will be covered and payable as long as the treatment is required as outlined in the alternative benefit plan and is less expensive than the original treatment plan which otherwise would have been followed. The Claims Administrator will determine the maximum approved payments allowable under the Plan.

Benefits under the Plan are furnished as an alternative to other Plan benefits and are limited to the following:

- Services, equipment and supplies which are approved as Medically Necessary for the treatment and care of the Member.
- Non-structural modifications to the home which are required to meet minimum standards for safe operation of equipment.
- When necessary for the long term care of the Member in the home-setting, respite care to relieve family members or other persons caring for the Member at home. (The respite care benefit can be credited at a rate of 24 hours for every month of care rendered in the home setting and may be reimbursed for up to 6 consecutive days at a time. The Claims Administrator may approve on an exception basis up to 5 days per month of respite care when medical review of the case indicates that such action is appropriate.

The Member must obtain pre-certification from the Claims Administrator regarding the treatment plan and proposed setting to be utilized during the respite care period.

Potential cases include but are not limited to:

- spinal cord Injury;
- severe head trauma/coma;
- respiratory dependence;
- degenerative muscular/neurological disorders;
- long term IV antibiotics;
- premature birth;
- burns;
- cardiovascular accident;
- cancer;
- accidents;
- terminal illnesses;
- other cases at the Plan's discretion.

Covered Services

- Services covered under individual case management will be determined by the Plan on a case-by-case basis. Benefits may be provided for the rehabilitation of a Member on an Inpatient, outpatient, or out-of-Hospital basis, as long as they are Medically Necessary, support the plan of treatment, and ensure quality of care.

- The program may provide or coordinate any of the types of Covered Services provided pursuant to this Benefit Booklet.
- At its sole discretion, in the context of an individual case management program, the Plan may also provide or arrange for alternative services or extra-contractual benefits which (i) are excluded by this Benefit Booklet; (ii) are neither excluded nor defined as Covered Services under this Benefit Booklet, or (iii) exceed the maximum for any Covered Service under this Benefit Booklet.

Utilization

- Benefits will be provided only when and for as long as the Plan deems they are Medically Necessary. The approved alternative benefit plan of treatment will establish which benefits will be provided and for how long and shall be subject to pre-certification and continuing review for Medical Necessity as set forth in such plan for treatment.
- The total benefits that may be paid will not exceed those which the Member would otherwise have received in the absence of individual case management benefits.

Exclusions

- Rehabilitation or Custodial Care for chronic (recurring) conditions that do not, in the Claims Administrator's sole discretion, significantly improve in an observable way within a reasonable period of time will not be a covered benefit under the individual case management program.

Provider

A Provider may be any facility or practitioner including, but not limited to Ineligible Providers, licensed or certified to give services or supplies consistent with the Plan of Treatment and approved by the Claims Administrator.

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

If a Member has other healthcare coverage under another program, any other group medical expense coverage, or any local, state or governmental program (except school accident insurance coverage and Medicaid), then benefits payable under This Plan will be coordinated with the benefits payable under the other program. This Plan's liability in coordinating will not be more than 100% of the Allowable Expense or the contracted amount.

Allowable Expense means any necessary, reasonable and customary expense at least a portion of which is covered under at least one of the programs covering the Member for whom the claim is made.

Please note that several terms specific to this section are listed below. Some of these terms have different meanings in other parts of the Benefit Booklet. For this provision only, your plan is referred to as "This Plan" and any other insurance plan as "Plan." In the rest of the Benefit Booklet, Plan has the meaning listed in the "Definitions" section.

Plan means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

- Group insurance or group-type coverage, whether insured or uninsured, that includes continuous twenty-four (24) hour coverage. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any Plan whose benefits, by law, are in addition to those of any private insurance program or other non- governmental program.

Note: The Comprehensive Care Healthcare Plan will be secondary to automobile insurance policies or contracts.

Each contract or other arrangement for coverage under bullet 1 or 2 above is a separate Plan. If an arrangement has two parts and these rules apply only to one of the two, each of the parts is a separate Plan.

Primary Plan/Secondary Plan - The "Order of Benefit Determination Rules" below determine whether This Plan is a Primary Plan or Secondary Plan in relationship to another Plan covering you. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

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

When there are more than two Plans covering you, This Plan may be a Primary Plan in relationship to one or more other Plans and may be a Secondary Plan in relationship to a different Plan or Plans.

Order of Benefit Determination Rules

When you have other coverage, claims will be paid as follows:

- Non-Dependent/Dependent

The program which covers the person as an Employee (other than as a dependent) is primary to the program that covers the person as a dependent.

- Dependent Child/Parents Not Separated or Divorced
 - For children, the healthcare plan of the parent whose birthday occurs earlier in the calendar year is deemed to be primary.
 - If both parents' birthdays occur on the same day, the healthcare plan that has insured the parent for the longest period of time is primary.
 - If one of the plans does not have the parent birthday rule, the father's healthcare plan is primary.
- Dependent Child/Parents Separated or Divorced
 - a. When a *court decree has determined that one parent has financial responsibility* for medical, dental or other healthcare expenses of a child, the healthcare plan of the parent with court-decreed financial responsibility is primary to any other plan covering the child (regardless of which parent has custody).
 - b. When a *court decree states that the parents will share joint custody*, without specifying which parent has financial responsibilities for medical or dental care expenses of a child, the plan providing primary coverage for the child will be determined as follows:
 1. The healthcare plan of the parent whose birthday occurs earlier in the calendar year is primary;
 2. When both parents' birthdays occur on the same day, the healthcare plan that has insured the parent for the longest period of time is primary; and
 3. If one of the plans does not have the parent birthday rule, the father's healthcare plan is primary.
 - c. In the absence of joint custody and without court-decreed financial responsibility:
 1. For healthcare plans that cover a *child of separated or divorced parents who have not remarried*, the healthcare plan of the parent with custody is deemed to be primary.
 2. For healthcare plans that cover a *child of remarried parent(s)*:
 - The healthcare plan of the remarried parent, with custody, is deemed to be primary;
 - The healthcare plan of the step-parent is deemed to be secondary; and
 - The healthcare plan of the biological parent, without custody, is deemed to have the third level of healthcare payment responsibility.
- Active/Inactive Employee
 - The healthcare plan that covers an insured individual as an active employee is primary over healthcare plan that covers a retiree or laid-off employee.
 - The same process is true for an active employee covered by his/her employer's group-insurance medical plan who is also covered as a dependent under a retiree's/laid-off employee's group-insurance medical plan.
 - An active employee's healthcare plan will have primary coverage responsibilities.

Facility of Payment

A payment made under another program may include an amount which should have been paid under This Plan. If it does, the Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this program. This Plan will not have to pay that amount again.

Right of Reimbursement

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

- the persons it has paid or for whom it has paid,
- insurance companies, or
- other organizations.

Right of Reimbursement

The Plan may require reimbursement from a covered member for benefits paid to the Member for an injury or illness involving negligence or misconduct of a third party if the Member is "made whole." A Member is made whole if the Member recovers amounts under a settlement or a judgment against a third party which is more than the sum of all economic and non-economic losses incurred as a result of an injury or illness. The amount of any reimbursement claim by the Plan will be reduced by the pro rata amount of the attorney's fees and expenses of litigation incurred by the Member in bringing a claim against the third party. The Plan has the right to seek a declaratory judgment in court to share in the proceeds of any settlement or judgment where the Member claims he or she has not been made whole.

Any person seeking recovery from a third party on behalf of a Member for personal injury related to a claim for which the Plan has paid benefits must provide notice of the claim by certified mail or statutory overnight delivery to the Plan. This notice must be provided no later than 10 days prior to the consummation of any settlement or commencement of any trial. Once the notice is received, the Plan will provide a notice to the Member for any claims for reimbursement.

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, the Claims Administrator is committed to making sure your rights are respected while providing your health benefits. That also means giving you access to the Claims Administrator's Network Providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private. This is as long as it follows state and Federal laws and our privacy policies.
- Get the information you need to help make sure you get the most from your Health Plan and share your feedback. This includes information on:
 - The Claims Administrator's company and services.
 - The Claims Administrator's network of doctors and other health care providers.
 - Your rights and responsibilities.
 - The rules of your health care plan.
 - The way your Health Plan works.
- Make a complaint or file an appeal about:
 - Your Plan
 - Any care you get
 - Any Covered Service or benefit ruling that your Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all Plan rules and policies.
- Choose a Network Primary Care Physician (doctor), also called a PCP, if your health care plan requires it.
- Treat all doctors, health care Providers and staff with courtesy and respect.

- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors or health care Providers.
- Give the Claims Administrator, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with the Plan.

The Claims Administrator is committed to providing quality benefits and customer service to its Members. Benefits and coverage for services provided under the benefit program are governed by the Plan and not by this Member Rights and Responsibilities statement.

If you need more information call the Member Services number on your ID card.

Your Rights to Appeal

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the Claims Administrator’s notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the Claims Administrator’s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan’s review procedures and the time limits that apply to them;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the Claims Administrator’s notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals (Grievances)

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You

or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. 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 file an appeal for a claim involving urgent/concurrent care, 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 the appeal should be processed on a more expedited basis.

All other requests for Appeals (Grievances) should be submitted in writing by the *Member* or the *Member's authorized representative*, except where the acceptance of oral *Appeals (Grievances)* is otherwise required by the nature of the *appeal* (e.g., urgent care). You or your authorized representative must submit a request for review to:

**Anthem Blue Cross and Blue Shield
Post Office Box 105449
Atlanta, GA 30348-5449**

You must include your Member Identification Number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the Plan, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale.

For Out of State Appeals (Grievances) - You have to file Provider Appeals with the Host Plan. This means Providers must file Appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level Appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is Experimental or Investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals (Grievances)

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary Appeals (Grievances) must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

Requirement to file an Appeal before filing a lawsuit

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 three years 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 Plan's internal Appeals Procedure but not including any voluntary level of appeal or the independent External Review, before filing a lawsuit or taking other legal action of any kind against the Plan.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section.

External Review

If the outcome of the mandatory first level appeal is adverse to you, 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. Claims submitted for External Review will be reviewed by a qualified medical professional who is not employed by the Claims Administrator or the Employer.

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 the Claims Administrator's 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 Member's identity;
- 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 the appeal should be processed on a more expedited basis.

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 Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 105449
Atlanta, GA 30348**

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 law

Continuation of Coverage under Federal Law (COBRA)

A Member who loses coverage under the Plan may be entitled to elect to continue coverage under the Plan, at his or her own expense, for 18-36 months after the coverage would otherwise end. These rights and the Member's responsibilities to protect his or her continuation rights are summarized below but contact your Employer if you have any questions about your COBRA rights. COBRA continuation coverage is generally administered by the "COBRA Administrator," which is the office or third-party that will be your point of contact after the original qualifying event. You will receive more information on how to contact the COBRA Administrator once you have elected continuing coverage.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when a Member's coverage under the Plan would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is a Member who is covered under the Plan on the day before the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

Each qualified beneficiary may elect continuation independently. Members also may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for continuation coverage.

Initial Qualifying Event	Length of Availability of Coverage
<p><u>For Employees:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked</p>	18 months
<p><u>For Spouses/ Dependents:</u> A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked</p> <p>Covered Employee's Entitlement to Medicare (if it leads to a loss of coverage under this Plan)</p> <p>Divorce or Legal Separation</p> <p>Death of a Covered Employee</p>	18 months 36 months 36 months 36 months
<p><u>For Dependents:</u> Loss of Dependent Child Status, e.g., turning age 26</p>	36 months

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

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

Second qualifying event

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

Notification Requirements

You must notify your (or the Employee's) campus Benefits/Human Resources office within 60 days of your divorce, legal separation or the failure of your enrolled Dependents to meet the program's definition of Dependent. This notice must be provided in writing to the campus Benefits/Human Resources Office. Thereafter, the COBRA Administrator will notify qualified beneficiaries of their rights to elect continuing coverage.

Electing COBRA Continuation Coverage

To continue enrollment, a qualified beneficiary must make an election within 60 days of the date your coverage would otherwise end or the date the COBRA Administrator notifies the qualified beneficiary of this right, whichever is later. You must pay the total premium appropriate for the type of benefit coverage you choose to continue. If the premium rate changes for active associates, your monthly premium will also change. The premium you must pay cannot be more than 102% of the total cost (Employee and Employer) of coverage available to active Employees with similar coverage, and it must be paid to the COBRA Administrator within 30 days of the date due, except that the initial premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

A qualified beneficiary who is determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, or who becomes disabled during the first 60 days of COBRA continuation coverage, may continue coverage for 29 months after the qualifying event. Family members of the disabled employee are also eligible for the disability extension. To qualify for the extension, the disabled qualified beneficiary must provide notice of his or her disability status within 60 days of the disability determination or the COBRA qualifying date, whichever is later. In these cases, the Employer can charge 150% of premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled individual at 29 months. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, the qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days

after the Social Security Administration's determination.

When COBRA Coverage Ends

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

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

Other Coverage Options Besides COBRA Continuation Coverage

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

Continuation of Coverage Due to Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), a Subscriber who is absent from employment on account of military leave may have a right to continuation of benefits. This right is nearly identical to COBRA except that (1) coverage is available for 24 months; and (2) the Employer pays the full premium after the first month of the absence (but not the additional 2% that is charged for COBRA continuation coverage) but pays only the active Employee rate for the first month of the absence.

Family and Medical Leave Act of 1993

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

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

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

Once the employee returns to work after his/her leave period ends, the Employee's coverage may be restored to the same level the Employee had prior to his/her leave period if the Employee continues to be eligible for coverage.

Please contact your Human Resources/Benefits Office for more Family and Medical Leave Act information.

For More Information

This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under this Plan is available from your campus Benefits/Human Resources Office or the appropriate COBRA Administrator.

General Provisions

Clerical Error

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

When Your Comprehensive Care Healthcare Plan Coverage Ends

Your coverage under this Plan will end on the last day of the month in which:

- You are no longer eligible to participate in the Plan;
- You elect to withdraw from the Plan during an open enrollment period (in the event of a Plan enrollment change during open enrollment, coverage will be effective January 1);
- Your employment is terminated;
- You fail to make any required employee contribution; or
- The Plan is terminated.

Confidentiality and Release of Information

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

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

Medicare

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

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

Modifications

The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any

Member. By electing benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not Liable for Provider Acts or Omissions

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

Policies and Procedures

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

The Claims Administrator may offer pilots only in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all, Members under the Plan. The Claims Administrator reserves the right to discontinue a pilot initiative at anytime.

Relationship of Parties (Employer-Member Claims Administrator)

Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

Right of Recovery

- If you or your Covered Dependents have a claim for damages or a right to reimbursement from a third party or parties for any condition, illness or Injury for which benefits are paid under this program, the Claims Administrator shall have a right of recovery. Our right of recovery shall be limited to the amount of any benefits paid for covered medical expenses under this program, Our right of recovery shall include compromise settlements. You or your attorney must inform us of any legal action or settlement discussion, ten days prior to settlement or trial. The Claims Administrator will then notify you of the amount the Claims Administrator seeks, and the amount of your legal expenses the Claims Administrator will pay.
- Whenever payment has been made in error, the Claims Administrator will have the right to recover such payment from you or, if applicable, the Provider. In the event the Claims Administrator recovers a payment made in error from the Provider, except in cases of fraud, the Claims Administrator will only recover such payment from the Provider during the 24 months after the date the Claims Administrator made the payment on a claim submitted by the Provider. The Claims Administrator reserves the right to deduct or offset any amounts paid in error from any pending or future claim payable under the Plan.
- The Claims Administrator has oversight responsibility for compliance with Provider and vendor and subcontractor contracts. The Claims Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible. 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.

- The Claims Administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Claims Administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.
- You agree to furnish such information and assistance and execute such papers as we may require to facilitate enforcement of our right of recovery. Relevant information includes, but is not limited to, police reports, pleadings, settlement agreements, and communications with any party regarding the accident, incident, injury or illness.
- Our rights are not limited by any allocation or characterization made in a settlement agreement or court order.

Workers' Compensation

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

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, the Plan will not pay any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Waiver

No agent or other person, except an authorized officer of the Employer, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Acts Beyond Reasonable Control (Force Majeure)

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

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

Definitions

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

Accidental Injury

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

Administrative Services Agreement

The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of this Plan.

Ambulatory Surgical Center

A facility licensed as an Ambulatory Surgical Center as required by law that satisfies our accreditation requirements and is approved by us.

Appeals

Please see the "Your Right to Appeal" section.

Applied Behavior Analysis (ABA)

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.

Authorized Service(s)

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

Balance Billing

The dollar amount charged by a Provider that is in excess of the Plan's allowed amount for medical care or treatment. Amounts that are balance billed by a Provider are the Member's responsibility. Member costs incurred for Balance Billing will not apply toward the annual Deductible or toward the annual Out-of-Pocket Maximum.

Benefit Booklet

This document. The Benefit Booklet provides you with a summary of your benefits while you are enrolled under the Plan.

Benefit Period

Each Benefit Period begins on January 1st and ends on December 31st. If your coverage ends before the end of the calendar year, then your Benefit Period also ends.

Benefit Period Maximum

The maximum amount that the Plan will pay for specific Covered Services during a Benefit Period.

Centers of Excellence (COE) Network

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

Claims Administrator

The company the Plan Sponsor chose to administer its health benefits. Blue Cross and Blue Shield of Georgia, Inc. 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

The fraction or percentage of the cost of a Covered Service that the Member is obligated to pay. If the Plan pays 90% of the network rate after a Deductible is satisfied, for example, the Member's Coinsurance is 10% of the network rate.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Care. See the "Benefit at a Glance" for details. Your Copayment will be the lesser of the amount shown in the "Benefit at a Glance" or the amount the Provider charges.

Covered Services

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

- Medically necessary or specifically included as a Covered Service under this BenefitBooklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental or Investigational, excluded, or limited by this Benefit Booklet, or by any amendment or rider to this Benefit Booklet.
- Approved by the Claims Administrator before you get the service if Pre-Certification or Prior Authorization is needed.

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

The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the Facility except as described in the "Termination and Continuation of Coverage" section.

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

Covered Transplant Procedure

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

Custodial Care

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

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

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

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

Deductible

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

Dependent

A Member of the Subscriber's family who meets the rules listed in the "Eligibility and Enrollment – Adding Members" section of this Benefit Booklet and who has enrolled in the Plan. Eligible Dependents are also referred to as Members.

Doctor

See the definition of “Physician.”

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the “What’s Covered” section.

Emergency Care

Please see the “What’s Covered” section.

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 whose Employees are eligible to participate in the Plan.

Excluded Services (Exclusion)

Health care services your Plan doesn’t cover.

Experimental or Investigational

Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence. Medical and scientific evidence means:

- 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;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medica (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t)(2) of the Social Security Act;
- The following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or

It meets the following five technology assessment criteria:

- The technology must have final approval from the appropriate government regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology of health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternative.
- The technology must be beneficial in practice.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Center, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, or mental health facility, as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

Facility Services

Services rendered at an inpatient acute, outpatient, residential treatment facility, partial hospital program or intensive outpatient program.

Health Plan or Plan

The health benefits Plan established by the Employer and summarized in this Benefit Booklet, as it may be amended from time to time.

Home Health Care Agency

A Provider licensed when required by law and approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of such services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that satisfies our accreditation requirements and is approved by us. The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

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

Identification Card (ID Card)

The latest card given to you showing your identification and group numbers, the type of coverage you have, and the date coverage became effective.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with the Claims Administrator, or another organization, to give Covered Services to Members through negotiated payment arrangements.

Inpatient

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

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

Maximum Allowed Amount

The maximum payment that the Claims Administrator will allow for Covered Services. For more information, see the "Claims Payment" section.

Medical Necessity (Medically Necessary)

The Claims Administrator reserves the right to determine whether a service or supply is Medically Necessary. The fact that a Doctor has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary. The Claims Administrator considers a service Medically Necessary if it is:

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- compatible with the standards of acceptable medical practice in the United States;
- not provided solely for your convenience or the convenience of the Doctor, health care provider or Hospital;
- not primarily Custodial Care;
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis; and
- cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.

Member

The Subscriber and his or her Dependents who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Benefit Booklet.

Mental Health and Substance Abuse

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Non-Preferred Provider

A Provider who is not In-Network for this Plan but is contracted for the Claims Administrator's insured products. See "Claims Payment" and "Maximum Allowed Amount" for more details on how claims from Non-Preferred Providers are paid.

Open Enrollment

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

Out-of-Network Provider

A Provider that does not have an agreement or contract with the Claims, or the Claims Administrator's subcontractor(s), to give services to Members under this Plan.

Out-of-Pocket Maximum

The most you pay during a Benefit Period for Covered Services before your Plan begins paying 100% of the covered charges. The Out-of-Pocket Maximum includes your Copayments and Coinsurance but does not include your premium, Deductible, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Benefit at a Glance" and the "Pharmacy Benefit Management (PBM)" sections for details, as there are separate Out-of-Pocket Maximums for medical care and prescription drugs.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

Physician (Doctor)

Includes the following when licensed by law:

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

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

Plan

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

Plan Sponsor

The University System of Georgia, 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.

Pre-certification

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

Predetermination

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

Primary Care Physician (“PCP”)

A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics, , geriatrics or any other practice allowed by the Plan.

Primary Care Provider

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

Prior Authorization

Please see the “Getting Approval for Benefits” and “Prescription Drugs Administered by a Medical Provider” sections for details.

Professional Services

Professional Services refers to the category of services rendered by a professional outside of an Inpatient or Outpatient Facility. Included are services provided by physicians and non-physicians, psychologists, nurse practitioners, optometrists, home health, therapists and others.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, satisfies our accreditation requirements and, for In-Network Providers, is approved by us. Details on our accreditation requirements can be found at **{Update if website changes:** <https://www.anthem.com/provider/credentialing/>}. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the number on the back of your Identification Card.

Referral

Please see the “How Your Plan Works” section for details.

Retail Health Clinic

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

Residential Treatment Center / Facility

An Inpatient Facility that treats Mental Health and Substance Abuse conditions. The Facility must be licensed as a residential treatment center in the state in which it is located and be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

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

Service Area

The geographical area where you can get Covered Services from an In-Network Provider, as approved by regulatory agencies.

Skilled Nursing Facility

A facility licensed as a skilled nursing facility in the state in which it is located that satisfies our accreditation requirements and is approved by us.

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

Special Enrollment

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

Specialist (Specialty Care Physician / Provider or SCP)

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

Subscriber

A person who is or was engaged in active employment with the Employer (the Employee) and is eligible for Plan coverage under the employment regulations of the Employer, including a retiree who is eligible for retiree coverage under this Plan.

Telemedicine Medical Service

A health care medical service initiated by a Doctor or provided by a health care professional, the diagnosis, treatment or consultation by a Doctor, or the transfer of medical data that requires the use of advanced communications technology:

- Compressed digital interactive video, audio, or data transmission.
- Clinical data transmission using computer imaging by way of still-image capture; and,
- Other technology that facilitates access to healthcare services or medical specialty expertise.

Neither a telephone conversation nor an electronic mail message between a healthcare practitioner and a patient is telemedicine.

Urgent Care Center

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

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card.

Access to Obstetrical and Gynecological (ObGyn) Care

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

Additional Federal Notices

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

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

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 your Employer or Plan Administrator provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

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 "Benefit at a Glance" for details.) If you would like more information on WHCRA benefits, call the number on the back of your Identification Card.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 31 days after your other coverage ends.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

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

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

To request special enrollment or obtain more information, call the Customer Service telephone number on your Identification Card, or contact your Employer.

Pharmacy Benefit Management (PBM) Program

CVS/Caremark is the Claims Administrator for the prescription drug benefit program provided in conjunction with this Plan. (Drugs administered by the Provider are covered under the Anthem portion of the Plan. See "Prescription Drugs Administered by a Medical Provider" in this Benefit Booklet for more information.)

Employees and dependents covered by the USG prescription drug benefit can use any participating network retail pharmacy, mail order pharmacy or specialty pharmacy. Members are not required to utilize CVS Pharmacy retail pharmacies. The 'pharmacy locator' tool can be found on the USG benefits page, under the pharmacy section, members may select "Locate a pharmacy near you" to view their pharmacy options to fill their prescriptions. To utilize the prescription drug benefit, show your Anthem ID card at the time you obtain your prescription at the participating Retail Network Pharmacy.

Your benefit covers most prescription drugs, plus insulin and some over-the-counter (OTC) diabetes supplies. This plan also covers both prescription and OTC preventative medications, considered preventative under the Affordable Care Act (ACA), at a \$0 copayment. To receive these medications at a \$0 copayment, you must have an authorized prescription for the product, and it must be dispensed by a participating mail or retail pharmacy. For specific prescribed drugs, the plan may impose certain requirements. Those requirements may include prior authorization, limits on the day supply amount of the prescribed medication, and/or limits on the number of approved units/ tablets of medication per prescription. Members should refer to the Prior Authorization, Step Therapy and Quantity Limit list on the USG HR – Benefits website for more details.

The Plan has a three-tiered pharmacy benefit program. This means that drugs are classified as generic, preferred brand name and non-preferred brand name drugs. Each tier has its own Copayment. Your Copayment will vary based on the specific medication that you and your Provider select. The use of generic prescription medications, when available, is the most cost-effective option for a Member. Please refer to the most up to date Formulary Drug List at the USG benefits website. Refer to the chart below for plan design.

		Copay/Coinsurance
Retail	Generic	\$15
	Preferred Brand	20% with \$40 min and \$100 max
	Non-preferred brand	35% with \$100 min and \$200 max
Mail Order	Generic	\$45
	Preferred Brand	20% with \$120 min and \$300 max
	Non-preferred brand	35% with \$300 min and \$600 max
Annual OOP Max	Employee	\$1,750
	Employee+CH	\$3,500
	Employee+Spouse	\$3,500
	Family	\$5,250

If approved for a 60-90-day supply, you will be responsible for 2x or 3x the coinsurance.

The pharmacy benefit limits all new specialty medications to a 30-day supply per fill. You will pay a percentage of the drug cost, also known as coinsurance, up to a maximum per 30-day supply.

Example assumes 30-day supply of a specialty medication

	Drug Cost	Coinsurance	You pay
Generic	\$750	20% with \$75 maximum	\$75
Preferred	\$2,500	20%, with \$150 maximum	\$150
Nonpreferred	\$7,500	35%, with \$200 maximum	\$200
Annual out-of-pocket maximum	Employee		\$1,750
	Employee+CH		\$3,500
	Employee+Spouse		\$3,500
	Family		\$5,250

For a list of specialty medications that fall under this tier, review the Specialty Drug list on benefits.usg.edu website.

Other Coverage Rules

- If the usual and customary charge for a generic or preferred brand name drug is less than the cost-sharing amount, the Member will pay the lesser of the two.
- If a physician indicates “Brand Necessary” on a prescription, then only a preferred or non-preferred brand name medication can be dispensed. The Member will be required to pay the generic copayment. In addition to paying the generic copayment, the Member will also be responsible for paying the difference in the cost between the generic and the preferred/non-preferred brand name drug. This difference in member cost is sometimes referred to as an “ancillary charge.”
- If you are only able to take brand-name medications, call CVS Caremark at **1-800-294-5979**.
- If a physician does not indicate “Brand Necessary,” and the Member chooses a preferred/non-preferred brand name medication over its available generic equivalent, the Member will be required to pay the generic copayment. In addition to paying the generic copayment, the Member will also be responsible for paying the difference in the cost between the generic and the preferred/non-preferred brand name drug. This difference in member cost is sometimes referred to as an “ancillary charge.”
- Maintenance medications are those prescription drugs that a member may obtain for a period of up to 90 days. The Member will be charged one copayment for each supply of medication up to a 30-day supply.
- The Plan covers certain preventive medications – both prescription and over-the-counter (OTC) at a \$0 Copayment. To receive these medications at a \$0 Copayment, you must have an authorized prescription for the product, and it must be dispensed by a participating mail or retail pharmacy.
- The cost-sharing for generic and non-preferred brand name prescription drugs under this CVS/Caremark portion of the Plan will apply towards your Prescription Drug Out-of-Pocket Maximum. The following annual Out-of-Pocket Maximums apply to your prescription drug coverage (other than Provider-administered prescription drugs):
- Once a Member reaches the Prescription Drug Out-of-Pocket Maximum, his or her prescription drug copayments and coinsurance will be waived for any additional generic, preferred brand, and non-preferred brand name drugs for the remainder of the plan year.
- For specific prescribed drugs, the plan may impose certain requirements. Those requirements may include prior authorization, limits on the day supply amount of the prescribed medication, and/or limits on the number of approved units/ tablets of medication per prescription.

Formulary or Preferred Drug List (PDL)

CVS Caremark maintains a preferred drug list (also known as a Formulary), manages a network of retail pharmacies and operates Mail Service and Specialty Drug pharmacies. In consultation with the plan, CVS

Caremark also provides services to promote the appropriate use of pharmacy benefits, such as review for possible excessive use, recognized and recommended dosage regimens, drug interactions and other safety measures.

The Preferred Drug List/Formulary is developed by an independent panel of doctors and pharmacists who ensure the medications are clinically appropriate and cost-effective. The pharmacy benefit plan was developed after extensive review, analyses, and recommendations.

The formulary is constantly reviewed so there may be formulary changes that occur quarterly throughout the year. Members who are impacted by changes will receive notification. Notification is sent to members and physicians 30-45 days prior to the effective date of the change. For members on specialty medications, they will also receive live outbound phone calls from the specialty team to address any changes. Please refer to the most up to date Formulary Drug List at the USG benefits website.

CVS Caremark Mail Service

Members who need medication on an ongoing basis can ask their doctor to prescribe up to a 90-day supply, plus refills (if appropriate) and may have these filled through CVS Caremark Mail Service Pharmacy. Examples of maintenance medications include: ongoing therapies to treat diabetes, high cholesterol, high blood pressure, and asthma. CVS Caremark Mail Service Pharmacy offers:

- Up to a 90-day supply of your medication
- No-cost standard shipping in a plain, weather-resistant package
- Flexible payment options and (if you elect) automatic refills
- Refill orders placed at your convenience, by telephone or online
- Access to a registered pharmacist any time, day or night

Getting started with mail service

You can begin using the CVS Caremark Mail Service Pharmacy for home delivery of your medications using one of the following options:

- **Online:** Register at **caremark.com** (link on USG Benefits website) to begin managing your prescriptions online. You can also download the CVS Caremark app to get started with mail service today.
- **By mail:** Ask your doctor to provide you with a written prescription for your medications. Sign in to **Caremark.com** to download and print a mail service form. Mail the prescription(s) along with a completed order form to the address below:

CVS Caremark
P.O. Box 94467
Palatine, IL 60094

Please note: To avoid delays in filling your prescription, be sure to include payment with your order. Please do not send correspondence to this address.

- **By fax or electronic submission from your doctor:** Your doctor's office can fax or electronically send the prescription for a 90-day supply, plus the appropriate number of refills (maximum one-year supply). Your doctor's office will have the appropriate fax number.
 - **Important notes:**
 - Faxes must be sent from your doctor's office. Faxes from other locations, such as your home or workplace, cannot be accepted.
 - For new prescriptions, please allow approximately one week from the day CVS Caremark Mail Service Pharmacy receives your request.
 - You must use 75% of your medication before you can request a refill through mail service (80% of your medication for controlled substances).

CVS Specialty®

CVS Specialty is a full-service pharmacy that provides your choice of home delivery service or delivery to your local CVS Pharmacy® for specialty medications. These medications are used to treat a number of complex conditions, such as cancer and multiple sclerosis. CVS Specialty does more than provide your medication, we help you stay on track so you can stay healthy longer. We do this by providing the support you need to help ensure you take them safely and effectively.

- **Getting started**

To get started, call a CVS Specialty representative at **1-866-387-2573** or register online at **CVSSpecialty.com**. You may also request that CVS Specialty contact your doctor for you, then call you to arrange for delivery of your medication on a day that is convenient for you. You may refill specialty medications one month at a time (maximum 30-day supply per copayment).

An important message for those who use specialty medications

Specialty medications are drugs that are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis, and rheumatoid arthritis. Whether they are administered by a healthcare professional, self-injected, or taken orally specialty medications require an enhanced level of service.

For access to specialty medications, you may use a specialty pharmacy. You may use CVS/ Specialty Pharmacy, or any specialty pharmacy, as not all specialty medications are covered through a retail pharmacy.

The CVS Caremark Specialty Pharmacy provides not only specialty medicines but also personalized pharmacy care management services:

- Access to a team of clinical experts that are specially trained in your condition
- On-call Care Team pharmacist 24 hours a day, seven days a week who can help you manage your condition by: checking dosing and medication schedules; answering your medication questions; helping you manage side effects; helping you set up new medication regimens; and checking that you are taking your medication as prescribed.
- Coordination of care with you and your doctor
- Convenient delivery to the address of your choice, including your doctor's office
- Medicine- and condition-specific education and counseling
- Insurance and financial coordination assistance
- Online support through www.cvsspecialty.com including condition-specific information and the specialty pharmacy drug list, fast refills, up-to-date prescription information and secure prescription information storage.

To get started or to find out whether any of your specialty medications need to be ordered through CVS/Specialty, please call 1-866-387-2573.

Free On-line Tests through the Federal Government – COVIDtests.gov

The federal government launched a COVID-19 OTC Tests website for U.S. households to obtain online tests. This site allows each household to order up to 4 free COVID-19 tests.

USG Healthcare Plan

Provides direct coverage or \$12 reimbursement for up to 8 tests per member per 30-day period.

Anthem members

For employees enrolled in the Consumer Choice HSA, Comprehension Care or BlueChoice HMO plans, tests are available through in-network pharmacies at no cost, if they are purchased through one of the two convenient options:

1. Order online through [CVS's Member Website](#) or through the CVS Mobile App. Covered tests will be available within the hour, at the location with available test kits.
2. At an [in-network pharmacy location](#). Covered tests must be purchased at the pharmacy counter. If you pay out-of-pocket for an OTC COVID test, you may request reimbursement online through the [CVS website](#). Members who choose this option will be reimbursed up to \$12 per test, up to the 8 test per 30-day limit.

Vacation Overrides

If you are going on vacation or out of the country and need an additional supply of medication, you reach out to CVS Caremark for approval. Please contact CVS Customer Care at **1-877-362-3922** for assistance. Members are allowed two vacation overrides per year, per medication. If you're requesting greater than a 90 day supply of medication as an override, that request will be reviewed on a case by case basis.

What's Not Covered under Your Prescription Drug Benefit

Certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1. **Administration Charges** - Charges for the administration of any drug except for covered immunizations as approved.
2. **Clinically-Equivalent Alternatives** - Certain Prescription Drugs may not be covered if you could use a clinically equivalent Prescription Drug, unless required by law. "Clinically equivalent" means Prescription Drugs that, for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Prescription Drug is covered and which Prescription Drugs fall into this group, please call the number on the back of your Identification Card or visit the Claims Administrator's website at www.caremark.com. If you or your Doctor believes you need to use a different Prescription Drug, please have your Doctor or pharmacist get in touch with the Claims Administrator. The other Prescription Drug will be covered only if it is Medically Necessary and appropriate over the clinically equivalent Prescription Drug. Benefits for the Prescription Drug will be reviewed from time to time to make sure the Prescription Drug is still Medically Necessary. Newly marketed drugs are not automatically covered.
3. **Compound Drugs** - Compound drugs unless there is at least one ingredient that you need a prescription for, and the Prescription Drug is not essentially a copy of a commercially available drug product.
4. **Contrary to Approved Medical and Professional Standards** - Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
5. **Delivery Charges** - Charges for delivery of Prescription Drugs.
6. **Drugs Given at the Provider's Office / Facility** - Drugs you take at the time and place where you are given them or where the prescription order is issued. This includes samples given by a Doctor. These drugs may be covered under the "Prescription Drugs Administered by a Medical Provider" section.
7. **Drugs That Do Not Need a Prescription** - Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

8. **Drugs Over Quantity or Age Limits Prescription** - Drugs in quantities which are over the limits set by the Plan, or which are over age limits set by the Claims Administrator.
9. **Drugs Over the Quantity Prescribed or Refills After One Year** - Prescription Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original
10. **Items Covered as Durable Medical Equipment (DME)** - Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors, and contraceptive devices. Items not covered under the "Pharmacy Benefit Management (PBM) Program" benefit may be covered under the "Durable Medical Equipment and Medical Devices, Orthotic, Prosthetics, and Medical and Surgical Supplies" benefit. Please see that section for details.
11. **Items Covered as Medical Supplies** - Contraceptive devices, oral immunizations, and biologicals, even if they are federal legend Prescription Drugs, are covered as medical supplies based on where you get the service or the item. Over the counter drugs, devices or products, are not Covered Services.
12. **Items Covered Under the "Allergy Services" Benefit** - Allergy desensitization products or allergy serum. While not covered under the "Pharmacy Benefit Management (PBM) Program" benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
13. **Lost or Stolen Drugs** - Refills of lost or stolen drugs.
14. **Non-approved Drugs** - Experimental drugs are not covered.
15. **Non-formulary Drugs** - Select Non-formulary drugs are not covered.
16. **Onychomycosis Drugs** - Select drugs for Onychomycosis (toenail fungus) except when allowed to treat Members who are immunocompromised or diabetic.
17. **Weight Loss Drugs** - Any drug mainly used for weight loss.

Drug Exclusion Plan Design Strategy, a design strategy providing plan benefit exclusion for drugs with limited clinical value

USG plan shall exclude from coverage certain drugs that have limited clinical value and which have clinically-appropriate, lower-cost alternatives (e.g., brand name drugs that are combinations of existing generic or over-the-counter drugs, new formulations of existing drugs). USG's designee, CVS Caremark, shall determine which drugs meet the criteria for exclusion.

Current Exclusions include:

Absorica, Absorica LD, Aplenzin, Duexis, Jublia, Kerydin, Nascobal, Sitavig, Vimovo and generic, Xerese, Zipsor, Zyflo

Affordable Care Act

Your plan offers certain preventive service benefits at \$0, which means you don't have to pay a copay. These no-cost benefits are part of the Affordable Care Act (ACA) and include:

- Medicine and supplements to prevent certain health conditions for adults, women and children
- Medicine and products for quitting smoking or chewing tobacco (tobacco cessation)
- Medicine used prior to screenings for certain health conditions in adults
- Contraceptives for women

CVS Caremark® works with your health plan to provide these benefits. For additional details, refer to “ACA Preventive Services List” link on caremark.com.

Terms you should know

Deductible | An individual or family needs to spend this amount on medications each plan year before coverage starts; may be combined with medical benefits

Copay or coinsurance | The amount you pay for medications once you or your family reaches the deductible and coverage starts; a copay is a flat amount and coinsurance is a percentage of the cost of the medication

Maximum out-of-pocket (MOOP) | Once you or your family reach this amount, all medications are covered at 100%

Generic medication | Has the same active ingredients as the brand-name medication; usually your lowest cost option

Preferred brand medication | Medication that will cost less under your benefit plan

Non-preferred brand medication | Highest cost option under your benefit plan

Maintenance or long-term medication | Medication you take regularly, like high blood pressure, diabetes, or high cholesterol medications

Acute or short-term medication | Medication you take for a short time, like an antibiotic

Preventive medication | Affordable Care Act (ACA) preferred medications are covered at 100%; High deductible health plan (HDHP) preventive medications bypass the deductible, which means they are covered even if you haven't met your yearly deductible yet

Quantity limit | A limit on the amount of medications your plan will cover. You can continue to fill prescriptions after you've reached the limit, but you'll be responsible for any additional costs.

Step therapy | For many conditions, more than one therapeutically equivalent medication option is available, and your plan may choose one medication as the preferred option. Step therapy means you need to try the preferred option first. If it works for you, you can continue to take it and may save money. If not, non-preferred medications will be covered.

Prior authorization | This means we need more information on why your doctor has prescribed a specific medication for you. CVS Caremark reviews this information and determines whether or not your medication will be covered by your plan.

Dispense as written | If your doctor indicates “dispense as written” on your prescription, your pharmacy can't substitute a generic for a brand name medication, and you may have to pay more for the brand.

Appeals | If we deny your or your doctor's request for coverage of a non-covered medication, you have the right to appeal that decision.

Brand Name Drug | The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

Generic Drugs | Prescription drugs that have been determined by the FDA to be equivalent to brand name drugs but are not made or sold under a registered trade name or trademark. Generic drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency, and must be dispensed in the same dosage form (tablet, capsule, cream) as the brand name drug.

CVS Caremark's Appeals Process

The CVS Caremark Claims and Appeals Process CVS Caremark's standard claims and appeals process complies with the requirements of the Affordable Care Act (ACA) and their implementing regulations. Members will be accorded all rights granted to them under ACA and any related laws and regulations. The claims and appeals process implemented for any Plan Sponsor will also comply with applicable law, as indicated by the Plan Sponsor on the Clinical Plan Management (CPM) form or other PDD documents. If indicated, CVS Caremark's review will also be conducted in compliance with any applicable state requirements or accreditation standards, including the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC).

Once you are notified that a claim is denied in whole or in part, you have the right to appeal. Requests appeals need to be received within 180 days of the initial denial. Appeals must be submitted in writing. Acceptable submission methods include fax or mail directly to CVS Caremark. All administrative and clinical appeals are reviewed according to the plan design provisions and a decision will be mailed within 15 business days of receipt of a written request by CVS Caremark for pre-service pre-authorization claims and within 30 days for post-service claims. Urgent pre-service claims will be processed within 72 hours from the receipt of the inquiry by CVS Caremark.

How to File an Appeal Request

You can submit all appeal requests by faxing to CVS Caremark at **1-866-443-1172**, or in writing to:

CVS Caremark

Attention: **Appeals Department MC 109**

P.O. Box 52084

Phoenix, AZ 85072-2084

Appeals of Adverse Benefit Determinations or Adverse Coverage Determinations

If an Adverse Coverage Determination is rendered on the member's Claim, the member may file an appeal of that determination. The member's appeal of the Adverse Coverage Determination must be made in writing and submitted to CVS Caremark within the time frame specified by applicable federal or state requirements after the member receives notice of the Adverse Benefit Determination or Adverse Coverage Determination.

If the Adverse Coverage Determination is rendered with respect to an Urgent Care Claim, the member and/or the member's authorized representative may submit an appeal by calling, faxing or mailing the request to CVS Caremark.

The member's appeal should include the following information:

- A clear statement that the communication is intended to appeal an Adverse Coverage Determination;
- Name of the person for whom the appeal is being filed. The member or prescriber may file an appeal. The member may also have a relative, friend, advocate, or anyone else (including an attorney) act on their behalf as their authorized representative;
- CVS Caremark identification number;
- Date of birth;
- A statement of the issue(s) being appealed;
- Drug name(s) being requested; and
- Comments, documents, records, relevant clinical information or other information relating to the Claim

CVS Caremark's Review

Review of Adverse Coverage Determinations: CVS Caremark provides a single-level appeal for Adverse Coverage Determinations. Upon receipt of an appeal of an Adverse Coverage Determination, CVS Caremark will review the member's request for a particular drug or benefit against the terms of the Plan, including the preferred drug lists, formularies or other defined plan benefits selected by the Plan Sponsor in the PDD.

Appeal Review Procedure:

- Provide for a full and fair review, allowing the member to review the Claim file and to present evidence and testimony. This includes providing the member (free of charge) with new or additional evidence or rationale relied upon in advance of a final internal Adverse Benefit Determination, and giving the member a reasonable opportunity to respond;
- Take into account all comments, documents, records and other information submitted by the member relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination of the Claim;
- Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Plan documents;
- Follow reasonable procedures to ensure that the applicable Plan provisions are applied to the member in a manner consistent with how such provisions have been applied to other similarly situated members;
- Provide a review that is designed to ensure the independence and impartiality of the person making the decision;
- Provide a review that does not give consideration to the initial Adverse Coverage Determination and is conducted by someone other than the individual who made the initial Adverse Coverage Determination (or a subordinate of such individual); and
- Provide for an expedited review process for Urgent Care Claims

For a claim requiring a Medical Necessity Review, CVS Caremark, in addition to the above, shall also:

- Consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

NOTICE OF PRIVACY PRACTICES

The broad mission and extensive scope of operations of the Board of Regents of the University System of Georgia, including the constituent colleges and universities of the University System of Georgia (collectively, the "Board"), necessitates that the Board collect, maintain, and, where necessary, disseminate health information regarding the Board's students, employees, volunteers, and others. For example, the Board collects medical information through its various medical and dental hospitals, clinics, and infirmaries, through the administration of its various medical and life insurance programs, and through its various environmental health and safety programs. The Board protects the confidentiality of individually identifiable health information that is in its possession. Such health information, which is protected from unauthorized disclosure by Board policies and by state and federal law, is referred to as "protected health information," or "PHI."

PHI is defined as any individually identifiable health information regarding an employee's, a student's, or a patient's medical/dental history; mental or physical condition; or medical treatment held on behalf of the Plan. Examples of PHI include patient name, address, telephone and/or fax number, electronic mail address, social security number or other patient identification number, date of birth, date of treatment, medical treatment records, medical enrollment records, or medical claims records.

The Board will follow the practices that are described in its Notice of Privacy Practices ("Notice"). The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise this Notice and post a new Notice in conspicuous locations.

Permitted Uses and Disclosures of PHI

The following categories describe the different ways in which the Board may use or disclose your PHI. We include some examples that should help you better understand each category.

The Board may receive, use, or disclose your PHI to administer your health and dental benefits plan. Please be informed that the Board, under certain conditions and circumstances, may use or disclose your PHI *without obtaining your prior written authorization*. An example of this would be when the Board is required to do so by law.

For Treatment. The Board may use and disclose PHI as it relates to the provision, coordination, or management of medical treatment that you receive. The disclosure of PHI may be shared among the respective healthcare providers who are involved with your treatment and medical care. For example, if your primary care physician needs to use/disclose your PHI to a specialist, with whom he/she consults regarding your condition, this would be permitted.

For Payment. The Board may use and disclose PHI to bill and collect payment for healthcare services and items that you receive. The Board may transmit PHI to verify that you are eligible for healthcare and/or dental benefits. The Board may be required to disclose PHI to its business associates, such as its claims processing vendor, to assist in the processing of your health and dental claims. The Board may disclose PHI to other healthcare providers and health plans for the payment of services that are rendered to you or to your covered family members by such providers or health plans.

For Healthcare Operations. The Board may use and disclose PHI as part of its business operations. As an example, the Board may require a healthcare vendor partner (referred to as a "business associate")

to survey and assess constituent satisfaction with healthcare plan design/coverage. Constituent survey results assist the Board in evaluating quality of care issues and in identifying areas for needed healthcare plan improvements. Business associates are required to agree to protect the confidentiality of your individually identifiable health information.

The Board may disclose PHI to ensure compliance with applicable laws. The Board may disclose PHI to healthcare/dental providers and health/dental plans to assist them with their required credentialing and peer review activities. The Board may disclose PHI to assist in the detection of healthcare fraud and abuse. Please be reminded that the lists of examples that are provided are not intended to be either exhaustive, or exclusive.

As Required by Law and Law Enforcement. The Board must disclose PHI when required to do so by applicable law. The Board must disclose PHI when ordered to do so in a judicial or administrative proceeding. The Board must disclose PHI to assist law enforcement personnel with the identification/location of a suspect, fugitive, material witness, or missing person. The Board must disclose PHI to comply with a law enforcement search warrant, a coroner's request for information during his/her investigation, or for other law enforcement purposes.

For Public Health Activities and Public Health Risks. The Board may disclose PHI to government agencies that are responsible for public health activities and to government agencies that are responsible for minimizing exposure to public health risks.

The Board may disclose PHI to government agencies that maintain vital records, such as births and deaths. Additional examples in which the Board may disclose PHI, as it relates to public health activities, include assisting in the prevention and control of disease; reporting incidents of child abuse or neglect; reporting incidents of abuse, neglect, or domestic violence; reporting reactions to medications or product defects; notifying an individual who may have been exposed to a communicable disease; or, notifying an individual who may be at risk of contracting or spreading a disease or condition.

For Health Oversight Activities. The Board may disclose PHI to a government agency that is authorized by law to conduct health oversight activities. Examples in which the Board may disclose PHI, as it relates to health oversight activities, include assisting with audits, investigations, inspections, licensure or disciplinary actions, and other proceedings, actions or activities that are necessary to monitor healthcare systems, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. The Board may disclose PHI to coroners, medical examiners, and funeral directors for the purpose of identifying a decedent; for determining a cause of death; or, otherwise as necessary, to enable these parties to carry out their duties consistent with applicable law.

Organ, Eye, and Tissue Donation. The Board may release PHI to organ procurement organizations to facilitate organ, eye, and tissue donation and transplantation.

Research. Under certain circumstances, the Board may use and disclose PHI for medical research purposes.

To Avoid a Serious Threat to Health or Safety. The Board may use and disclose PHI to law enforcement personnel or other appropriate persons. The Board may use and disclose PHI to prevent or lessen a serious threat to the health or safety of a person or the public.

Specialized Government Functions. The Board may use and disclose PHI for military personnel and veterans, under certain conditions, and if required by the appropriate authorities. The Board may use and disclose PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities.

The Board may use and disclose PHI for the provision of protective services for the President of the United States, other authorized persons, or foreign heads of state. The Board may use and disclose PHI to conduct special investigations.

Workers' Compensation. The Board may disclose PHI for worker's compensation and similar programs. These programs provide benefits for work-related injuries or illnesses.

Appointment Reminders/Health Related Benefits and Services. The Board and/or its business associates may use and disclose your PHI to various other business associates that may contact you to remind you of a healthcare or dental appointment. The Board may use and disclose your PHI to business associates that will inform you of treatment program options, or, of other health related benefits/services such as Condition Care Management Programs.

Disclosures for HIPAA Compliance Investigations. The Board must disclose your PHI to the Secretary of the United States Department of Health and Human Services (the "Secretary") when so requested. The Secretary may make such a request of the Board to investigate its compliance with privacy regulations of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Uses and Disclosures of Your PHI to Which You Have an Opportunity to Object

You have the opportunity to object to certain categories of uses and disclosures of PHI that the Board may make:

Patient Directories. Unless you object, the Board may use some of your PHI to maintain a directory of individuals in its hospitals or provider facilities. This information may include your name, your location in the facility, your general condition (e.g., fair, stable, etc.), and your religious affiliation. Religious affiliation may be disclosed to members of the clergy. Except for religious affiliation, the information that is maintained in a patient directory may be disclosed to other persons who request such information by referring to your name.

Disclosures to Individuals Involved in Your Health Care or Payment for Your Health Care. Unless you object, the Board may disclose your PHI to a family member, another relative, a friend, or another person whom you have identified as being involved with your healthcare, or, responsible for the payment of your healthcare. The Board may also notify these individuals concerning your location or condition.

Fundraising Activities. Unless you object, the Board may disclose your PHI to contact you for fundraising efforts to support the Board, its related foundations, and/or its cooperative organizations. Such disclosure would be limited to personal contact information, such as your name, address and telephone number. The money raised in connection with these fundraising activities would be used to expand and support the provision of healthcare and related services to the community.

If you object to the use of your PHI in any, or all, of the three instances identified above, please notify your campus or facility privacy officer, in writing.

Other Uses and Disclosures of Your PHI for Which Authorization Is Required

Certain uses and disclosures of your PHI will be made only with your written authorization. Please be advised that there are some limitations with regard to your right to object to a decision to use or disclose

your PHI.

Regulatory Requirements. The Board is required, by law, to maintain the privacy of your PHI, to provide individuals with notice of the Board's legal duties and PHI privacy practices, and to abide by the terms described in this Notice.

The Board reserves the right to change the terms of its Notice and of its privacy policies, and to make the new terms applicable to all PHI that it maintains. Before the Board makes an important change to its privacy policies, it will promptly revise its Notice and post a new Notice in conspicuous locations. You have the following rights regarding your PHI:

You may request that the Board restrict the use and disclosure of your PHI. The Board is not required to agree to any restrictions that you request, but if the Board does so, it will be bound by the restrictions to which it agrees, except in emergency situations.

You have the right to request that communications of PHI to you from the Board be made by a particular means or at particular locations. For instance, you might request that communications be made at your work address, or by electronic mail, rather than by regular US postal mail. Your request must be made in writing. Your request must be sent to the privacy officer on your campus or facility. The Board will accommodate your reasonable requests without requiring you to provide a reason for your request.

Generally, you have the right to inspect and copy your PHI that the Board maintains, provided that you make your request in writing to the privacy officer on your campus or your facility. Within thirty (30) days of receiving your request (unless extended by an additional thirty (30) days), the Board will inform you of the extent to which your request has, or, has not been granted. In some cases, the Board may provide you with a summary of the PHI that you request, if you agree in advance to a summary of such information and to any associated fees. If you request copies of your PHI, or agree to a summary of your PHI, the Board may impose a reasonable fee to cover copying, postage, and related costs.

If the Board denies access to your PHI, it will explain the basis for the denial. The Board will explain your opportunity to have your request and the denial reviewed by a licensed healthcare professional (who was not involved in the initial denial decision). This healthcare professional will be designated as a reviewing official. If the Board does not maintain the PHI that you request, but it knows where your requested PHI is located; it will advise you how to redirect your request.

If you believe that your PHI maintained by the Board contains an error or needs to be updated, you have the right to request that the Board correct or supplement your PHI.

Your request must be made in writing to the privacy officer on your campus or in your facility. Your written request must explain why you desire an amendment to your PHI.

Within sixty (60) days of receiving your request (unless extended by an additional thirty (30) days), the Board will inform you of the extent to which your request has, or, has not been granted. The Board generally can deny your request, if your request for PHI: (i) is not created by the Board, (ii) is not part of the records the Board maintains, (iii) is not subject to being inspected by you, or (iv) is accurate and complete.

If your request is denied, the Board will provide you a written denial that explains the reason for the denial and your rights to: (i) file a statement disagreeing with the denial, (ii) if you do not file a statement of disagreement, to submit a request that any future disclosures of the relevant PHI be made with a copy of your request and the Board's denial attached, and (iii) complain about the denial.

You generally have the right to request and receive a list of the disclosures of your PHI that the Board has made at any time during the six (6) years prior to the date of your request (provided that such a list would not include disclosures made prior to April 14, 2003).

The list will not include disclosure for which you have provided a written authorization, and will not include

certain uses and disclosures to which this Notice already applies, such as those: (i) for treatment, payment, and health care operations, (ii) made to you, (iii) for the Board's patient directory or to persons involved in your healthcare, (iv) for national security or intelligence purposes, or (v) to correctional institutions or law enforcement officials.

You should submit any such request to the privacy officer on your campus or in your facility. Within sixty

(60) days of receiving your request (unless extended by an additional thirty (30) days), the Board will respond to you regarding the status of your request. The Board will provide the list to you at no charge. If you, however, make more than one request in a year, you will be charged a fee for each additional request. You have the right to receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically. This notice may be found at the Board website address, www.usg.edu/legal/. To obtain a paper copy of this notice, please contact your campus or facility privacy officer.

You may complain to the Board if you believe your privacy rights, with respect to your PHI, have been violated by contacting the privacy officer on your campus or in your facility. You must submit a written complaint. The Board will in no manner penalize you or retaliate against you for filing a complaint regarding the Board's privacy practices. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services. You may contact the Secretary by calling 1-866-627- 7748 (outside of metropolitan Atlanta) or (404) 562-7886 (in metropolitan Atlanta).

If you have any questions about this notice, please contact the Human Resources office on your campus or in your facility. For additional information, please contact the privacy officer on your campus or facility.

Effective Date: April 14, 2003

PLEASE NOTE:

On the following page you will find the **CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION** form. This form provides a spouse or another person/class of persons (organization) with the authority to act on behalf of another member. A signed authorization form provides access to PHI (protected health information) for an individual/organization other than the contract holder.

Should you need to access PHI for another individual, we ask that you photocopy this form and submit the completed form to your campus Human Resource/Benefits Office. Your institutional Human Resource/Benefits Office will forward a copy to the vendor (Business Associate/Agent) associated with your request.

CONSENT FOR AUTHORIZATION FOR USE/RELEASE OF HEALTH INFORMATION

This authorization form applies only to the release and disclosure of protected health information (PHI). This authorization is not for treatment or intended for any other purpose.

By signing this form, I authorize my college, my university, my facility, or the University System office and Business Associates/Agents to use, release, or disclose the protected health information described below to:

Name and address of person/organization to whom information may be sent:

Name: _____

Address: _____

Transmit this information or about _____ (insert date). Information will not be resent absent reauthorization.

This authorization expires upon fulfillment of this request unless special circumstances apply.

Purpose for disclosure: _____

I authorize the following information to be sent to the address above:

____ Copies of all medical records for the period ____ / ____ / ____ to ____ / ____ / ____.

____ Copies of information described below for period ____ / ____ / ____ to ____ / ____ / ____.

____ History and Physical Examination ____ Lab Reports ____ Reports from Physicians

____ Other (specify) _____

I understand that this information may include any history of acquired immunodeficiency (AIDS); sexually transmitted diseases (STD); human immunodeficiency virus (HIV) infection; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

Please include on a separate piece of paper any other special instructions or limitations.

I understand that there may be information in these records that I would not wish to be released. I have been provided with a copy of my college, university, facility, or University System policies and procedures for HIPAA Compliance and any changes thereto which may be associated with this authorization. I have been provided an opportunity to discuss any concerns I may have about the use or misuse of my health information with my institutional or facility privacy officer or other appropriate personnel.

I understand that my institution or facility, the University System of Georgia, or the Board of Regents of the University System of Georgia assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release the Board of Regents of the University System of Georgia and its agents and employees from all legal liability that may arise from this authorization.

Name (please print): _____ Address: _____

Telephone: _____ Group No.: _____

Member ID Number: _____

Social Security Number: _____

Signed: _____

Date of Birth: _____ Date this Authorization Executed: _____

If the signature above is not that of the person whose medical records are authorized to be released, I am acting for the person whose medical records are being authorized for release:

My relationship to such person is: _____ Signed: _____

FUTURE OF THE PLAN

The Board of Regents of the University System of Georgia is the Plan Sponsor for the University System of Georgia Comprehensive Care Healthcare Plan. While the University System of Georgia expects the University System of Georgia Comprehensive Care Healthcare Plan to remain in effect, the University System of Georgia reserves the right to change the Plan or any benefit under the plan from time to time. The University System of Georgia also may discontinue the plan or any benefit under the plan at any time.

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