Anthem Blue Cross and Blue Shield (Anthem)

Health Reimbursement Arrangement (HRA) Plan Summary Plan Description (SPD)

FOR

SHBP
State Health Benefit Plan
A Division of the Georgia Department of Community Health

HRA OPTIONS: GOLD, SILVER and BRONZE

Administered By

Anthem

sharecare

CVS caremark

Effective Date: January 1, 2021

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

If you need assistance with Spanish translation to understand this SPD, you may request it at no additional cost by calling the Anthem Member Services at the number on your Member Identification Card (ID card).

INTRODUCTION

This Summary Plan Description ("SPD") gives you a description of your Benefits while you are enrolled under the State Health Benefit Plan (the "Plan"). The SHBP is a Calendar Year Plan. The Benefit Period starts on January 1, 2021 and ends on December 31, 2021. The Department of Community Health (DCH) reserves the right to act as sole interpreter of all the terms and conditions of the Plan, except where expressly delegated to the claims administrators. You should read this SPD carefully and keep it handy for reference. A thorough understanding of your coverage will allow you to maximize your Benefits. If you have any questions about the Benefits shown in this SPD, please call the Anthem Member Service number on your Member ID Card, provided by the medical claims administrator.

The purpose of this Health Reimbursement Arrangement ("HRA") option is to pay most of the costs of Medically Necessary medical care, treatment of illness, and accidental injury for Covered Services after a Deductible has been satisfied.

The Plan Benefits described in this SPD are for eligible Health Plan Members only. Throughout this SPD, you will also see references to "we", "us", "our", "you" and "your". The words "we", "us" and "our" mean the Department of Community Health, SHBP Division. The words "you" and "your" mean the Covered Person and each covered Dependent. Covered Services are subject to the limitations, exclusions, Deductible and Co-insurance rules given in this SPD. Any group plan or certificate which you may have received before will be replaced by this SPD.

Note: Please refer to the Eligibility and Enrollment Provisions document that contains the Plan's eligibility requirements at www.shbp.georgia.gov, posted separately as part of the SPD.

Many words used in this SPD have special meanings (e.g. Covered Services and Medical Necessity). These words are capitalized and are defined in the "Definitions" Section. See these definitions for the best understanding of what is being stated.

If you have any questions about your Plan, please be sure to call the Member Services number listed on your Member ID Card. Also, be sure to go to the Medical Claims Administrator's website, www.anthem.com/shbp for details on how to find a Provider, get answers to questions, and access valuable health tips. For more information about your Pharmacy Benefits see the "Outpatient Prescription Drug Rider" Section of this SPD or go to your Pharmacy Benefits Administrator's website, info.caremark.com/shbp. For more information about your Wellness Benefits, see the "Well-Being Program" in the Sharecare Section of this SPD or go to the Wellness Administrator's website, www.BeWellSHBP.com. If you have any enrollment or eligibility questions, call the SHBP Member Services at 800-610-1863 or visit www.mySHBPga.adp.com.

The Benefits described in this SPD or any rider or amendments attached hereto are funded by the Plan Sponsor who is responsible for a portion of their payment. Anthem Blue Cross and Blue Shield (Anthem) provides administrative medical claims payment services only, and CVS Caremark only provides administrative pharmacy claims payment services. Sharecare is the Well-Being program administrator.

How to Get Language Assistance

The Plan is committed to communicating with Members about the Plan. Simply call the Anthem Member Services number on your Member ID Card, and a representative will be able to help you. TTY/TDD services also are available.

STATE HEALTH BENEFIT PLAN (SHBP) CONTACT / RESOURCES INFORMATION

	Member	Website
Medical Claims Administrator- Anthem Blue Cross and Blue Shield Member Services Hours: 8:00 a.m. – 8:00 p.m. ET Monday – Friday Fraud Hotline 24 / 7 Nurse Line Personal Health Coach Hours: 8:00 a.m. – 6:00 p.m. ET Future Moms Behavioral Health	855-641-4862 (TTY 711) 855-641-4862 (TTY 711) 866-787-6361 866-901-0746 866-901-0746, Option 2 855-679-5722	www.anthem.com/shbp
Wellness Program Administrator- Sharecare Member Services Hours: 8:00 a.m. - 8:00 p.m. ET Monday – Friday Corporate Compliance	888-616-6411 (TTY 711) 844-401-0005 (TTY 711)	www.BeWellSHBP.com
Pharmacy Benefits Administrator- CVS Caremark Member Services Hours: 24 hours a day / 7 days a week TTY Line Fraud Hotline	844-345-3241 800-231-4403 877-CVS-2040	info.caremark.com/shbp
SHBP Member Services Hours: 8:30 a.m. – 5:00 p.m. ET Monday – Friday	800-610-1863	www.mySHBPga.adp.com
Additional Information		
Centers for Medicare & Medicaid (CMS) 24 hours a day / 7 days a week	800-633-4227 TTY 877-486-2048	www.medicare.gov

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SCHEDULE OF BENEFITS

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

All Covered Services are subject to the Medical Claims Administrators' policies, Plan limitations, Plan Benefit Exclusions, terms and conditions of this SPD including any endorsements, amendments, or riders.

To receive the highest level of benefits at the lowest out-of-pocket cost, receive Covered Services from an In-Network Provider. An In-Network Provider during an office visit may utilize, order, or refer you to other Providers for additional services. To maximize your Benefits, ask your In-Network provider to utilize or refer you to other In-Network Providers. Examples include, but are not limited to, laboratory (known as reference laboratory services) and radiology. For more information, call the Anthem Member Services number on your Member ID Card.

Co-insurance is a percentage of the Maximum Allowed Amount, which is the most the Medical Claims Administrator will allow for a Covered Service. When you use an In-Network Provider, you are not responsible for amounts above the Maximum Allowed Amount. Deductibles, Co-insurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges. Please read the "Medical Claims Payment" section for more details.

Note: Pharmacy Benefits are administered separately by the Pharmacy Benefits Administrator, CVS Caremark and are the same in all Plan Options- Gold, Silver, and Bronze Health Reimbursement Arrangement (HRA) Plans. See the table "Prescription Drug Pharmacy Benefits" in this Section & the "Outpatient Prescription Drug Rider" Section in this SPD.

SHBP Base HRA Credits Contributions to Your HRA	Gold HRA Plan	Silver HRA Plan	Bronze HRA Plan
You	400	200	100
You + Spouse	600	300	150
You + Children	600	300	150
You + Family	800	400	200

NOTE: HRA credits will reduce your Deductible and Out-of-Pocket Maximum. Prescription costs do apply to your HRA credits when credits are available.

If you do not use all of the HRA credits in your HRA, the credits roll over from year to year, as long as you remain continuously enrolled in a SHBP plan option (excluding the TRICARE Supplement). See "Well-Being Program" in the Sharecare Section of the SPD on how to earn HRA well-being incentive points.

Deductible	Gold HRA Plan		Silver HRA Plan		Bronze HRA Plan	
SHBP Coverage Tier	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
You	$1,500	$3,000	$2,000	$4,000	$2,500	$5,000
You + Spouse	$2,250	$4,500	$3,000	$6,000	$3,750	$7,500
You + Children	$2,250	$4,500	$3,000	$6,000	$3,750	$7,500
You + Family	$3,000	$6,000	$4,000	$8,000	$5,000	$10,000

The Deductible applies to all Covered Services unless otherwise indicated.

No benefits are payable until the Calendar Year Deductible is satisfied, unless otherwise indicated. HRA credits will reduce your Deductible.

The Deductible amount any one person can satisfy cannot be more than the You deductible.

The In-Network and Out-of-Network Deductibles are separate and cannot be combined. Covered Services by Out-of-Network Providers are processed as Out-of-Network and subject to the Member's Out-of-Network Deductible and Co-insurance.

Member Prescription costs do not apply to the Deductible.

Note: You + Spouse, You + Child(ren) or You + Family Deductibles are aggregate Deductibles. This means any combination of amounts paid by these tiers for Covered Services can be used to satisfy the applicable tiered Deductible.

Co-insurance	Gold HRA Plan In-Network	Silver HRA Plan In-Network	Bronze HRA Plan In-Network	Out-of-Network (All Plans)
Plan Pays (unless otherwise noted)	85%	80%	75%	60%
Member Pays (unless otherwise noted)	15%	20%	25%	40%

Your Co-insurance for In-Network Providers will be based on the Maximum Allowed Amount for Covered Services.

Your Co-insurance for Out-of-Network Providers will be based on the Maximum Allowed Amount for Covered Services. Covered Services by Out-of-Network Providers are processed as Out-of-Network and subject to the Member's Out-of-Network Co-insurance.

Note: Pharmacy benefits are administered separately by the Pharmacy Benefits Administrator and are the same in all Plan Options- Gold, Silver, and Bronze HRA Plans.

Out-of-Pocket Maximum	Gold HRA Plan		Silver HRA Plan		Bronze HRA Plan	
SHBP Coverage Tier	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
You	$4,000	$8,000	$5,000	$10,000	$6,000	$12,000
You + Spouse	$6,000	$12,000	$7,500	$15,000	$9,000	$18,000
You + Children	$6,000	$12,000	$7,500	$15,000	$9,000	$18,000
You + Family	$8,000	$16,000	$10,000	$20,000	$12,000	$24,000

The Out-of-Pocket Maximum limit includes all Deductibles and Co-insurance you pay during a Benefit Period unless otherwise indicated.

The Out-of-Pocket Maximum for an individual is equal to and will not be more than the You Out-of-Pocket Maximum.

The Out-of-Pocket Maximum does not include amounts you pay for the following benefits:

- Penalties for not getting required Prior Authorization / Precertification of services
- Amounts you pay for non-Covered Services

HRA credits will reduce the Out-of-Pocket Maximum

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

Proration does not apply to the Out-of-Pocket Maximum.

Member Prescription costs do apply to the Out-of-Pocket Maximum.

Once the Out-of-Pocket Maximum is satisfied, you will not have to pay any additional Deductibles or Co-insurance for medical and/or pharmacy Covered Services for the rest of the Benefit Period, except for the services listed above.

Gold, Silver, & Bronze HRA Plans	
Prescription Drug Pharmacy Benefits Co-insurance you must pay	
31-day supply for a participating Retail Network Pharmacy	
Tier 1 Co-insurance (Generic drugs and some select preferred Brand-name drugs)	15% ($20 min/ $50 max) for up to 31-day supply
Tier 2 Co-insurance (Preferred drugs)	25% ($50 min/ $80 max) for up to 31-day supply
Tier 3 Co-insurance (Non-Preferred drugs)	25% ($80 min/ $125 max) for up to 31-day supply
90-day Supply for maintenance drugs from mail order OR at participating 90-Day Retail Network Pharmacies	
Tier 1: 2½ x the monthly Co-insurance	15% ($50 min/ $125 max) for up to a 90-day supply
Tier 2: 2½ x the monthly Co-insurance	25% ($125 min/ $200 max) for up to a 90-day supply
Tier 3: 2½ x the monthly Co-insurance	25% ($200 min/ $312.50 max) for up to a 90-day supply
90-day Supply for maintenance drugs from a Retail Network Pharmacy which is not part of the 90-Day Retail Network Pharmacies	
Tier 1: 3 x the monthly Co-insurance	15% ($60 min/ $150 max) for up to a 90-day supply
Tier 2: 3 x the monthly Co-insurance	25% ($150 min/ $240 max) for up to a 90-day supply
Tier 3: 3 x the monthly Co-insurance	25% ($240 min/ $375 max) for up to a 90-day supply

Prescription drug pharmacy benefits are administered separately by the Pharmacy Benefits Claims Administrator, CVS Caremark and are the same in all three Plan options- Gold, Silver, and Bronze HRA Plans.

Co-insurance for a Prescription Drug Product at Network Pharmacy is a percentage of the allowed amount. Your Co-insurance is based on the applicable drug tier. Co-insurance will not be overridden or changed on an individual basis.

Please see the “Outpatient Prescription Drug Rider” in this SPD.

If a Generic product is available and you or your physician choose to use the Branded product instead, then you will pay the applicable Brand Co-insurance plus the cost difference between the Generic product and its Brand product, referred to as Ancillary Charge. This differential will not apply to your Out-of-Pocket Maximum.

Note: Prescription costs do not apply to the Deductible but do apply to the Member’s Out-of-Pocket Maximum.

Note: Please refer to the Preferred Drug List by visiting info.caremark.com/shbp.

Cost shares you must pay for Covered Services Please refer to the Section "What is Covered" for additional detail				
Covered Services	**Gold Plan In-Network**	**Silver Plan In-Network**	**Bronze Plan In-Network**	**Out-of-Network (All Plans)**
Allergy Services (Testing and Treatment)				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Ambulance Services (Air, Water and Ground)				
	15% Co-insurance per trip after Deductible	20% Co-insurance per trip after Deductible	25% Co-insurance per trip after Deductible	Same as In-Network
Out-of-Network Providers may also bill you for any charges that exceed the Plan's Maximum Allowed Amount. **Important Note:** Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. All scheduled ground 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.				
Autism Spectrum Disorder (ASD) Applied Behavior Analysis (ABA)				
	15% Co-insurance not subject to Deductible	20% Co-insurance not subject to Deductible	25% Co-insurance not subject to Deductible	Same as In-Network
Important Note: Prior Authorization is required and is limited to medically necessary ABA for the treatment of ASD.				
Cardiac Rehabilitation				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
○ **Cardiac Rehabilitation Benefit Maximum**		40 visits per Benefit Period In- and Out-of-Network visits combined		
Note: The limit for cardiac rehabilitation will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.				

Cost shares you must pay for Covered Services Please refer to the Section "What is Covered" for additional detail				
Covered Services	**Gold Plan In-Network**	**Silver Plan In-Network**	**Bronze Plan In-Network**	**Out-of-Network (All Plans)**
Chemotherapy / Non-Preventive Infusion & Injection				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Chiropractic Services / Osteopathic Manipulation Therapy				
• Office Visits and Physician Services: Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
○ **Chiropractic Services/Osteopathic Manipulation Therapy Benefit Maximum**	20 visits per Benefit Period In- and Out-of-Network visits combined			
Diagnostic Services Advanced Diagnostic Imaging (including MRIs, CAT scans) Diagnostic Labs (non-preventive) (i.e., reference labs) Diagnostic X-ray (non-preventive)				
• Inpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Dialysis / Hemodialysis				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible

Cost shares you must pay for Covered Services Please refer to the Section "What is Covered" for additional detail				
Covered Services	**Gold Plan In-Network**	**Silver Plan In-Network**	**Bronze Plan In-Network**	**Out-of-Network (All Plans)**
Durable Medical Equipment (DME) and Medical Devices, Orthotics, Prosthetics, Medical and Surgical Supplies (Received from a Supplier)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Emergency Services				
Emergency Room				
• Emergency Room Facility Charge	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
• Emergency Room Doctor Charge	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
• Non-emergency use of Emergency Room Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Note: Emergency services will be covered whether you receive care from an In-Network or Out-of-Network Provider. Please see the "Emergency Care" section of this document for more information.				
Foot Orthotics (Covered for certain diagnoses such as diabetes)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
○ **Foot Orthotics Benefit Maximum**	1 pair every 3 years			
Hearing (Non-routine Exam, Test & Fitting) and Hearing Aids				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP) Non- Routine Hearing Exams, Tests & Fittings	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Same as In-Network
• Hearing Aids	0% Co-insurance No Deductible	0% Co-insurance No Deductible	0% Co-insurance No Deductible	Same as In-Network
○ **Hearing Aid Benefit Maximum**	Limited to: $1,500 every 5 years for adults and $3,000 every 4 years for children (0 up to 19) per hearing impaired ear			

Cost shares you must pay for Covered Services Please refer to the Section "What is Covered" for additional detail				
Covered Services	**Gold Plan In-Network**	**Silver Plan In-Network**	**Bronze Plan In-Network**	**Out-of-Network (All Plans)**
Home Care				
• Home Care Visits • Home Dialysis • Home Infusion Therapy • Other Home Care Services / Supplies	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Hospice Care				
• Home Care • Respite Hospital Stays	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
○ **Bereavement Benefit Maximum**	8 Visits			
Note: Out-of-Network Providers may also bill you for any charges over the Plan's Maximum Allowed Amount.				
Human Organ and Tissue Transplant (Bone Marrow /Stem Cell) Services				
Precertification and Prior Approval required (except for cornea and kidney)				
• Transportation and Lodging	15% Co-insurance no Deductible	20% Co-insurance no Deductible	25% Co-insurance no Deductible	Not Covered unless *BDCT Facility used.
• Transportation and Lodging Limit	Covered, as approved by Anthem, up to $10,000 per transplant Out-of-Network Not Covered $50 per day for the patient or up to $100 per day for the patient plus one companion			
• Donor Search	15% Co-insurance no Deductible	20% Co-insurance no Deductible	25% Co-insurance no Deductible	Not Covered unless *BDCT Facility used.
• Donor Search Limit Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Transplant Procedure	Covered, as approved by Anthem, up to $30,000 Lifetime Maximum Out-of-Network Not Covered			
Note: *Anthem has Centers of Excellence (COE) Network selected to provide specific services to Members. Members must use a Blue Distinction Center for Transplants (BDCT) or one of the Center of Medical Excellence (CME) Transplant Network facilities to receive benefits for transplant services. Contact Anthem Member Services at the number on your Member ID Card for details.				

Cost shares you must pay for Covered Services Please refer to the Section "What is Covered" for additional detail				
Covered Services	**Gold Plan In-Network**	**Silver Plan In-Network**	**Bronze Plan In-Network**	**Out-of-Network (All Plans)**
Infertility Services				
Limited to diagnostic services. **Note:** Treatment of infertility is not covered.	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Inpatient Facility Services				
Facility Room & Board Charge: • Hospital / Acute Care Facility • Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Doctor Service Charges: • General Medical Care / Evaluation and Management (E&M) • Surgery & Other Doctor Charges	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Note: For Emergency admissions, you (or your authorized representative) or Doctor must inform Anthem within 48 hours of the admission.				
Maternity and Reproductive Health Services				
• Maternity Services • Prenatal Office Visit Services • Physician Office Visits Primary Care Physician (PCP) / Specialty Care Physician (SCP) **Note:** Deductible applies to mother and well-newborn charges.	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Inpatient Services (Delivery) • Inpatient Facility Services* • Inpatient Doctor Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
***Note:** Separate deductibles may apply for the mother and well-newborn facility charges.				
Note: Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged home, Covered Services for the newborn will be treated as a separate admission requiring precertification with Deductible and Co-insurance applied. You must also add the dependent to the Plan. Please refer to the Eligibility and Enrollment Provisions document that contains the Plan's eligibility requirements, posted separately as part of the SPD, at www.shbp.georgia.gov.				

Cost shares you must pay for Covered Services Please refer to the Section "What is Covered" for additional detail				
Covered Services	**Gold Plan In-Network**	**Silver Plan In-Network**	**Bronze Plan In-Network**	**Out-of-Network (All Plans)**
Mental Health and Substance Abuse Services				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Inpatient Facility Services • Inpatient Doctor Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services • Outpatient Doctor Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Partial Hospitalization Program/ Intensive Outpatient Program Services including Residential Treatments Centers and Methadone Clinics	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Nutritional Counseling & Childhood Obesity				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	0% Co-insurance No Deductible	0% Co-insurance No Deductible	0% Co-insurance No Deductible	Same as In-Network
○ **Nutritional Counseling – Benefit Maximum**	Nutritional Counseling Benefit Maximum: 3 visits per medical condition per lifetime by a Registered Dietitian (except for childhood obesity listed below)			
• Childhood Obesity	0% Co-insurance No Deductible	0% Co-insurance No Deductible	0% Co-insurance No Deductible	Same as In-Network
○ **Benefit Maximum**	Nutritional Counseling Children (Childhood Obesity) Benefit Maximum: For ages 3-18 with a 4-visit limitation per Calendar Year for Physicians and a 4-visit limitation per Calendar Year for Registered Dietitians who qualify as determined by their Physician.			
Note: Under the medical benefit for these non-preventive services, Out-of-Network covered at the In-Network level of benefits at the billed amount.				
Occupational Therapy				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
○ **Occupational Therapy Benefit Maximum**	40 visits per Benefit Period In- and Out-of-Network visits combined			
Note: The limit for occupational therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.				

Cost shares you must pay for Covered Services Please refer to the Section "What is Covered" for additional detail				
Covered Services	**Gold Plan In-Network**	**Silver Plan In-Network**	**Bronze Plan In-Network**	**Out-of-Network (All Plans)**
Office Visits and Physician Services				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Online Visits (LiveHealth Online)	15% Co-insurance not subject to Deductible	20% Co-insurance not subject to Deductible	25% Co-insurance not subject to Deductible	Not Covered
• Retail Health Clinic Visit	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Office Surgery	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Prescription Drugs Administered in the Office	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Outpatient Facility Services				
• Doctor Surgery Charges • Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist) • Non-chemotherapy Injection/Infusion Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Physical Therapy				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
○ **Physical Therapy Benefit Maximum** (Limit does not apply to children under age 19 with Congenital Anomalies. The child will also have to be in case management and meet Medical Necessity criteria.)	40 visits per Benefit Period In- and Out-of-Network visits combined			
Note: The limit for physical therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.				

Cost shares you must pay for Covered Services Please refer to the Section "What is Covered" for additional detail				
Covered Services	**Gold Plan In-Network**	**Silver Plan In-Network**	**Bronze Plan In-Network**	**Out-of-Network (All Plans)**
Preventive Care	0% No Deductible or Co-insurance	0% No Deductible or Co-insurance	0% No Deductible or Co-insurance	Not Covered
Note: Preventive care services must meet the requirements of federal and state law. Certain Preventive care services are Covered Services with no Deductible or Co-insurance when you utilize an In-Network Provider and the service is properly coded as preventive care. This means the Plan covers 100% of the Maximum Allowed Amount with no Member cost share for these certain Covered Services provided by an In-Network Provider.				
Radiation Therapy				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Respiratory and Pulmonary Therapy				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
○ **Respiratory Therapy Benefit Maximum**	40 visits per Benefit Period In- and Out-of-Network visits combined			
Skilled Nursing Facility				
• Skilled Nursing Facility / Rehabilitation Services (Includes Services in an Outpatient Day Rehabilitation Program)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	Not Covered
○ **Skilled Nursing / Rehabilitation Services Benefit Maximum**	120 days per Benefit Period			

Cost shares you must pay for Covered Services Please refer to the Section "What is Covered" for additional detail				
Covered Services	**Gold Plan In-Network**	**Silver Plan In-Network**	**Bronze Plan In-Network**	**Out-of-Network (All Plans)**
Speech Therapy				
• Office Visits and Physician Services Primary Care Physician (PCP) / Specialty Care Physician (SCP)	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
• Outpatient Facility Services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
○ **Speech Therapy Benefit Maximum**	40 visits per Benefit Period In- and Out-of-Network visits combined			
Note: The limit for speech therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit, or as mandated by state law for treatment of autism.				
Surgery				
	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Temporomandibular and Craniomandibular Joint Treatment				
	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Urgent Care Services				
	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Vision Exam				
For routine services	0% No Deductible or Co-insurance	0% No Deductible or Co-insurance	0% No Deductible or Co-insurance	Not Covered
○ **Vision Exam Benefit Maximum**	1 Exam every 24 months			
Note: Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit when provided by an In-Network Provider and properly coded as Preventive Care.				

Cost shares you must pay for Covered Services Please refer to the Section "What is Covered" for additional detail				
Covered Services	**Gold Plan In-Network**	**Silver Plan In-Network**	**Bronze Plan In-Network**	**Out-of-Network (All Plans)**
Vision Services				
For non-routine services	15% Co-insurance after Deductible	20% Co-insurance after Deductible	25% Co-insurance after Deductible	40% Co-insurance after Deductible
Note: Eye refraction testing is covered. Vision hardware includes one pair of glasses or contact lenses following cataract surgery within 12 months of the surgery. Diabetic retinal eye exams are covered.				
Wigs				
	0% Co-insurance after Deductible	0% Co-insurance after Deductible	0% Co-insurance after Deductible	Same as In-Network
○ **Wigs Benefit Maximum**	$750 per Lifetime, subject to Medical Necessity			
Note: Wigs are excluded regardless of the reason for the hair loss, with the exception of hair loss relating to cancer/chemotherapy treatment.				

HOW THE HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN WORKS

The HRA offers you a different approach for managing your health care costs. SHBP funds HRA credits to your HRA to provide first dollar coverage for those Covered Services requiring a Deductible, Co-insurance and pharmacy Co-insurance. The HRA well-being incentive credits are used to reduce your out-of-pocket amount you must pay. After satisfying your Deductible, you will pay your Co-insurance amount for Covered Services until you reach your Out-of-Pocket Maximum. If you do not use all your HRA credits, the HRA credits roll over from year to year, as long as you remain continuously enrolled in a SHBP plan option (excluding the TRICARE Supplement).

HRA consists of the following components:

1. HRA is funded by the SHBP and maintained by Anthem. SHBP contributes base HRA credits at the beginning of the Plan year to your HRA. These credits are used to help pay for medical Covered Services and pharmacy Co-insurance as available in your HRA.

SHBP Coverage Tier	Gold Base HRA Credits	Gold HRA after completion of all 2021 incentive actions (base HRA credits + 2021 points redeemed as well-being incentive credits*)	Silver Base HRA Credits	Silver HRA after completion of all 2021 incentive actions (base HRA credits + 2021 points redeemed as well-being incentive credits*)	Bronze Base HRA Credits	Bronze HRA after completion of all 2021 incentive actions (base HRA credits + 2021 points redeemed as well-being incentive credits*)
You	400	880	200	680	100	580
You + Child(ren)	600	1,080	300	780	150	630
You + Spouse	600	1,560	300	1,260	150	1,110
You + Family	800	1,760	400	1,360	200	1,160

***When 2021 well-being incentive points are redeemed for well-being incentive credits**

Note: SHBP Members will have access to a variety of Sharecare tools, activities, and services to earn well-being incentive points. To learn more, please see the Sharecare Section of this SPD, visit www.BeWellSHBP.com, or call Sharecare's Member Services at the number on your Anthem Member ID Card.

2. You are responsible for paying your annual Deductible before the Plan begins to pay a percentage for Covered Services. The credits in your HRA are used to help meet your Deductible. If you've been enrolled in the plan for more than one year, you may have enough saved to pay for your entire Deductible. After you meet your Benefit year Deductible, you pay a percentage of the Maximum Allowed Amount for Covered Services called Co-insurance. If you still have HRA credits in your HRA after you have met your annual Deductible, you can use those HRA credits to pay your share of Co-insurance. Once you reach your annual Out-of-Pocket Maximum, the Plan pays 100 percent for any Covered Services incurred during the remaining Benefit year.

Note: The Deductibles and Out-of-Pocket Maximums are separate for In-Network and Out-of-Network Covered Services.

3. **Redeem well-being incentive credits through Sharecare's Redemption Center.** Members and/or covered spouses can redeem well-being incentive credits to their HRA. If you have available well-being incentive credits in your HRA at the time a claim is received, the credits will be applied to eligible medical and pharmacy claims. Please see the Sharecare Section of this SPD for more details.

4. **Additional Health Information online tools and customer service support.** Members have access to Anthem and CVS Caremark online tools and Member Services to have a better understanding of their medical and pharmacy costs.

Regarding Your SHBP Health Reimbursement Arrangement (HRA):

- The HRA credits placed in your HRA will depend on the option elected by the Member. For example, if enrolled in the Bronze Option at the beginning of the Benefit year in the single tier, SHBP will fund 100 credits in this account.
- If you are a new hire or newly enrolled in the HRA Option within the plan year, the HRA credits in your HRA will be pro-rated based on the number of months remaining in the Benefit year. The Deductible and Out-of-Pocket Maximum are not pro-rated.
- If you experience a qualifying event and increase your coverage tier, your new HRA credits will be pro-rated based on the number of months remaining in the Benefit year.
- If you experience a qualifying event and decrease your coverage tier, the amount placed in your HRA for that plan year will not change.
- If you or an enrolled Dependent(s) experience a qualifying event which results in coverage under a new contract, the entire Deductible and Out-of-Pocket Maximum under the new contract will have to be met (This does not apply in cases where you are a surviving spouse or a dependent staying on the HRA plan after the retired subscriber moves to Medicare Advantage). See the Eligibility and Enrollment Provisions document posted at www.shbp.georgia.gov for more information. All HRA balances, Deductibles and Out-of-Pocket Maximums will remain with the prior contract. Pro-rated HRA credits will be deposited into the new contract based on the elected coverage tier and months remaining in the current plan year. Deductibles and Out-of-Pocket Maximums are not pro-rated.
- If your employment terminates for any reason, the credits in your HRA will be forfeited, unless you elect COBRA coverage and remain under the same contract. See the Eligibility and Enrollment Provisions document posted at for COBRA coverage details. The HRA credits will remain available to assist you in paying your out-of-pocket costs while COBRA coverage is in effect.

Covered Services received from an In-Network Provider

When you receive Covered Services requiring Deductible and/or Co-insurance from an In-Network Provider, the HRA credits in your HRA may be used to help you meet your Benefit year Deductible and Out-of-Pocket Maximum. Once the Benefit year Deductible is met, you are responsible for your cost share for those Covered Services requiring Co-insurance. HRA credits remaining in your HRA may be used to assist you in paying this difference.

Filing a Claim for Out-of-Network Benefits

If you have HRA credits in your HRA and you receive health services from an Out-of-Network Provider, you are responsible for filing a request for reimbursement. The request for claim reimbursement from your HRA credits may be made for claims incurred while you are considered a Covered Person under your medical plan.

Required Information for Filing an Out-of-Network Claim

When you request reimbursement from your HRA, you must complete the HRA Claim Form and attach the itemized documentation as described on that form. The form is available on www.anthem.com/shbp or by calling the Anthem Member Services number on your Member ID Card.

MEDICAL CLAIMS ADMINISTRATOR

HOW YOUR MEDICAL PLAN WORKS

Anthem is the Medical Claims Administrator for SHBP. Your Plan is an Open Access (OA) Point of Service (POS) Preferred Provider Organization (PPO) plan, otherwise known as the SHBP network. Providers who are not contracted with Anthem are considered Out-of-Network for Covered Services. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Deductible and Co-insurance and you will not be responsible for billed charges above the Maximum Allowed Amount.

In-Network Services and Providers

In-Network Providers include Primary Care Physicians/Providers (PCP), Specialty Care Physicians/Providers (SCP), other professional Providers, Hospitals, and other Medical Facilities who contract with Anthem to provide health care services.

Members have access to primary and specialty care directly from any In-Network Provider. A Primary Care Physician/Provider (PCP) Referral is not needed.

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

When you call or go to see a Doctor, tell them you are an Anthem SHBP Plan Member. Keep your Member ID Card with you. The Doctor's office will ask you for your group or Member ID number and usually make a copy of your card.

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 applicable Deductibles, and Co-insurance). You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this SPD.
2. Precertification will be done by the In-Network Provider. See the Section "Getting Approval for Benefits" further details.

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

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. Call your Doctor's office for after hour's instructions if you need care in the evenings, weekends, or during a holiday, and cannot wait until the office reopens. If you are not sure where to go for care and your Doctor is not available, you can also call the 24/7 Nurse Line at 866-787-6361 or go to LiveHealthOnline.com. Refer to Office Visits and Physician Services in the What is Covered section for other covered services.

Remember, if you are having an Emergency, call 911 or go to the nearest Emergency Room.

Out-of-Network Services and Providers

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

For Covered Services from an Out-of-Network Provider:

1. The Out-of-Network Providers can bill you the Out-of-Network Deductible and/or Co-insurance plus any amount above the plan's Maximum Allowed Amount;
2. You may have higher cost sharing amounts (i.e., Deductibles, and/or Co-insurance);
3. You will have to pay for services that are not Medically Necessary;
4. You will have to pay for non-Covered Services;
5. You may have to file claims; and
6. You must make sure any necessary Precertification is done. (Please see "Getting Approval for Benefits" for more details.)

How to Find a Provider in the Network

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

- View the directory of In-Network Providers at www.anthem.com/shbp, which lists the Doctors, Providers, and Facilities that participate in Anthem's Open Access Point of Service (POS) Preferred Provider Organization (PPO) plan.
- Call the Anthem Member Services to ask for a list of Doctors and other Providers that participate in the network, based on specialty and geographic area.
- Check with your Doctor or Provider.

Note: An In-Network Provider during an office visit may utilize, order, or refer you to other Providers for additional services. To maximize your In-Network benefits, your In-Network provider must utilize or refer you to other In-Network Providers. Examples include, but are not limited to, laboratory (known as reference laboratory services) and radiology. A Reference Laboratory is a freestanding lab outside the Physician's office such as LabCorp. For more information, call the Anthem Member Services number on your Member ID Card.

If you need help choosing a Doctor, call the Anthem Member Services number on your Member ID Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Anthem to help with your needs. Please note that Anthem has several networks, and that a Provider that is In-Network for one plan may not be In-Network for another. You may call Anthem Member Services on the back of your Anthem Member ID Card.

Your Cost-Shares

See the "Definitions" Section for a better understanding of each type of cost share as shown in the Schedule of Benefits table.

The BlueCard Program

Anthem is licensed in Georgia and participates in a program called "BlueCard". This program gives you access to Providers participating in the Blue Cross and Blue Shield Association BlueCard network across the country. The BlueCard network allows Covered Services at the In-Network cost-share when you are traveling outside of the State of Georgia and need health care, as long as you use a BlueCard Provider. All you have to do is show your Member ID Card to a participating Blue Cross and Blue Shield Provider. The Provider will send your claims to BCBS. To find the nearest contracted Provider, visit the BlueCard Doctor and Hospital Finder website at www.BCBS.com or call the number on your Anthem Member ID Card.

Note: If you are out-of-state and an emergency or urgent situation arises, you should get care right away.

Blue Cross Blue Shield Global Core Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States.

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

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

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

How Claims are Paid with Blue Cross Blue Shield Global Core

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

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

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

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

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

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

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

Identification Card (ID card)

Anthem will give each Member enrolled in the Plan an ID Card. When you get care, you must show your Member ID Card. Only covered Members have the right to receive services under this Plan. If anyone gets services or Benefits they are not entitled to under the terms of this SPD, he/she must pay for the actual cost of all the services.

GETTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Prior Authorization, Precertification, Predetermination and Post Service Clinical Claims Reviews to determine 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 the place of service) in which these 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.

The Medical Claims Administrator, Anthem, will use clinical coverage guidelines, such as medical policy, preventive care clinical coverage guidelines, and other applicable policies to help make Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. Anthem reserves the right to review and update these clinical coverage guidelines. If you have any questions about the information in this Section, call the Anthem Member Services number on your Member ID Card.

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 and clinical guidelines. Anthem may determine that a service that was first prescribed or requested is not Medically Necessary if you have not tried other treatments which are more cost effective.
- **Precertification –** A required prospective review of a service, treatment, admission or continued stay review for a determination of benefit coverage.
- **Predetermination –** An optional, voluntary prospective or a request for a benefit coverage determination regarding a service or treatment. The Predetermination coverage review will include a review to see if there is a related clinical coverage guideline or medical policy, the service meets the definition of Medical Necessity under this Plan, is it Experimental / Investigational as that term is defined in this Plan, or a Benefit Exclusion under the Plan.
- **Post Service Clinical Claims Review –** A retrospective review for a benefit coverage determination: (1) to verify Medical Necessity; (2) to determine if the service rendered is a Covered Benefit; (3) to determine if it is of an Experimental / Investigational nature of a service, treatment or admission that did not need Precertification, and (4) if it did not have a Predetermination review performed. The reviews are done for a service, treatment or admission in which Anthem has a related clinical coverage guideline policy, and are typically initiated by Anthem.

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

Who is Responsible for Getting Approval	
Services provided by an In-Network Provider, including BlueCard Providers in the service areas of various Anthem Blue Cross and Blue Shield States: CA, CO, CT, IN, KY, ME, MO, NH, NV, NY, OH, NA, WI	In-Network Provider
Services provided by any Out-of-Network or Non-Participating Provider.	Member must obtain Precertification. If Member fails to obtain Precertification, Member may be financially responsible for service and/or setting in whole or in part.

You are entitled to ask for and receive, at no cost, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on your Member ID Card.

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

Certain qualifying Providers may also be selected to take part in a program that exempts Anthem from certain procedural or medical management processes that would otherwise apply. Anthem may also exempt your claim from medical review, if certain conditions apply.

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

You may find out whether a Provider is taking part in certain programs by checking your online Provider directory or by contacting the Anthem Member Services on your Member ID Card.

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

Request Categories

- **Urgent:** A request for Precertification or Predetermination, that in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, could 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/treatment.
- **Prospective:** A request for Precertification or Predetermination that is conducted before the service, treatment or admission into a health care Facility.
- **Continued Stay Review:** A request for Precertification or Predetermination that is conducted during the course of outpatient treatment or during an Inpatient admission into a health care Facility.
- **Retrospective:** A request for Precertification that is conducted after the service, treatment or admission into a health care Facility 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.

Decision and Notice Requirements

Anthem will review requests for benefits according to the timeframes listed on the next page. Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on your Anthem Member ID Card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request

Request Category	Timeframe Requirement for Decision and Notification
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make a decision, Anthem will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to complete the review. If Anthem does not get the specific information needed or if the information is not complete by the timeframe identified in the written notice, a decision will be made based upon the information received.

Anthem will give notice of its determination (as required by state and federal law) by either:

- **Verbal:** Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider, or
- **Written:** Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider, and you / your authorized representative

Note: Precertification/Prior Authorization does not guarantee coverage for or payment of the service or treatment reviewed. Prior Authorization does not guarantee eligibility. For Benefits to be covered, on the date you receive a service:

1. You must be eligible for Benefits;
2. The service or supply must be a Covered Service under your Plan;
3. The service cannot be subject to an Exclusion under your Plan; and
4. You must not have exceeded any applicable limits under your Plan.

Services Requiring Precertification/Prior Approval

Note: To obtain Precertification or Prior Approval, Members must call the Anthem Personal Health Coach team at 855-668-6442 for the certain services to be provided by either an In-Network or an Out-of-Network provider. This is a dedicated line to obtain Precertification/Prior Approval. Read your SPD carefully regarding Covered Services. If you are not sure if a service is covered and requires Precertification, please call Member Services at 855-641-4862. Services that require Precertification/Prior Authorization include:

AIM Specialty Health℠ (AIM)

- Radiology – Diagnostic Services (CT scan, CTA, MRA, MRI, PET Scan)
- Cardiac – Diagnostic Services (Echocardiography or Nuclear Cardiology)
- Sleep Testing and Therapy Services
- Radiation Therapy
- Musculoskeletal (MSK)
    - Spine Surgery
    - Vertebroplasty/Kyphoplasty
    - Shoulder Replacement

- Hip Replacement
- Knee Replacement
- Ankle Replacement
- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Meniscal Allograft Transplantation of the Knee
- Treatment of Osteochondral Defects of the Knee and Ankle

Inpatient Services

- Acute Inpatient (including transplants)
- Sub-acute inpatient (Skilled Nursing and Long-Term Care)
- Inpatient Rehabilitation
- Maternity delivery if inpatient stay extends 48 hours for NVD and 96 hours following caesarean
- Out-of-network or out-of-area non-emergency services
- Emergency Admissions (Requires Plan notification no later than 2 business days after admission)

Diagnostic Testing

- Cardiac Ion Channel Genetic Testing
- Chromosomal Microarray Analysis for Autism, Developmental Delay and Congenital Anomalies
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Genetic testing for cancer susceptibility, BRCA Genetic Testing Program
- Prostate Saturation Biopsy
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders

Durable Medical Equipment (DME)/Prosthetics

- Bone Growth Stimulation: Electrical or Ultrasound
- Communication/speech generating devices, augmentative and alternative (ACC) / Augmentative and Alternative Communication (AAC) Devices/ Speech Generating Devices (SGD)
- Dynamic Low-Load Prolonged-Duration Stretch Devices
- Functional electrical stimulation (FES); threshold electrical stimulation (TES)
- Implantable Infusion Pumps
- Lower Limb Prosthesis and Microprocessor Controlled Lower Limb Prosthesis
- Oscillatory devices for airway clearance including high frequency chest compression (Vest™ airway clearance system) and intrapulmonary percussive ventilation (IPV)
- Prosthetics: Myoelectric Upper Extremity Prosthetic Devices
- Standing frames
- Transtympanic micropressure for the treatment of Meniere's disease
- Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)

Transplant

- Acute Inpatient (including transplants)
- Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
  - Donor Leukocyte Infusion
  - Intrathecal treatment of Spinal Muscular Atrophy (SMA)
  - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
  - (CAR) T-cell immunotherapy treatment
    - Axicabtagene ciloleucel (Yescarta™)
    - Tisagenlecleucel (Kymriah™)
    - Brexucabtagene Autoleucel (Tecartus)
- Gene Therapy Treatment & Replacement

Behavioral Health Services

Please call 1-855-679-5725 for Behavioral Health Precertification

- Inpatient Mental Health/Substance Abuse (in-network/out-of-network) within 24 hours of admission.

- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Treatment
- Behavioral Health Intensive in-home Programs
- Applied Behavioral Analysis (ABA) Therapy

Outpatient and/or other Inpatient Services

- Abdominoplasty ,Panniculectomy, Diastasis Recti Repair
- Ablative Techniques as a Treatment for Barrett's Esophagus
- Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting
- Air Ambulance (excludes 911 initiated emergency transport)
- Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Axial Lumbar Interbody Fusion
- Balloon and Self-Expanding Absorptive Sinus Ostial Dilation
- Blepharoplasty, Blepharoptosis repair, and Brow lift
- Bone-Anchored and Bone Conduction Hearing Aids
- Brachioplasty
- Breast procedures including reduction mammaplasty, reconstructive surgery, implants, and other breast procedures
- Bronchial Thermoplasty for Treatment of Asthma
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Cardio-reduction, partial left ventriculectomy
- Cardioverter defibrillators, implantable (ICD)
- Carotid, Vertebral and intracranial artery angioplasty
- Catheter-based Embolization Procedures for Malignant Lesions Outside the Liver
- Chin Implant, Mentoplasty, Osteoplasty Mandible
- Clinical Trials
- Cochlear implants and auditory brainstem implants
- Computer-assisted musculoskeletal surgical navigational for orthopedic procedures
- Corneal Collagen Cross-Linking
- Cosmetic and reconstructive services of the head and neck; trunk and groin
- Cosmetic and reconstructive services, skin related
- Cryosurgical or Radiofrequency Ablation to Treat Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Dental Care due to accident or injury
- Diaphragmatic/Phrenic Nerve Stimulation and Diaphragm Pacing Systems
- Electric Tumor Treatment Field
- Endovascular Techniques for Arterial Revascularization of the Lower Extremities
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Hyperbaric oxygen therapy (systemic/topical)
- Immunoprophylaxis for respiratory syncytial virus (RSV)/ Synagis (palivizumab)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implantable Middle Ear Hearing Aids
- Implanted Devices for Spinal Stenosis
- Insertion/injection of prosthetic material collagen implants
- Intervertebral discs, cervical artificial and lumbar artificial
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Liposuction/lipectomy
- Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease
- Lumbar Discography
- Lung Volume Reduction Surgery

- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- Mechanical Embolectomy for Treatment of Acute Stroke
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Occipital nerve stimulation
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Percutaneous and Endoscopic Spinal Surgery
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Perirectal Spacers for Use During Prostate Radiotherapy
- Penile prosthesis implantation
- Photocoagulation of Macular Drusen
- Presbyopia and astigmatism-correcting intraocular lenses
- Procedures Performed on Male or Female Genitalia
- Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
- Procedures Performed on the Trunk and Groin
- Repair of pectus excavatum/carinatum
- Sacral Nerve Stimulation and Percutaneous Tibial Nerve Stimulation for Urinary and Fecal Incontinence
- Sacral nerve stimulation as treatment of neurogenic bladder secondary to spinal cord injury
- Sacroiliac joint fusion
- Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
- Skin-Related Procedures
- Specialty Medications/Injectable Medications
- Spinal artificial intervertebral discs
- Subtalar Arthroereisis
- Surgical and Ablative Treatments for Chronic Headaches
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Surgical Treatment of Obstructive Sleep Apnea and Snoring (Nasal)
- Therapeutic Apheresis
- Transanal Hemorrhoidal Dearterialization (THD)
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation
- Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- Transcatheter Heart Valve Procedures
- Transcatheter Uterine Artery Embolization
- Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia
- Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
- Treatment of Hyperhidrosis
- Treatment of Temporomandibular Disorders
- Treatment of Varicose Veins (Lower Extremities)
- Treatments for Urinary Incontinence
- Vagus nerve stimulation
- Venous Angioplasty with or without Stent Placement
- Viscocanalostomy and Canaloplasty

Specialty Medications

Specialty Medications may be covered under the medical benefit with Anthem, the pharmacy benefit through CVS Caremark or both. To verify if pre-certification is required for a specific specialty medication under the medical plan, please call 1-855-668-6442.

Pre-Determination:

Though not required, a pre-determination of benefits is strongly recommended before incurring medical costs for certain services. The following are some examples of services, but not limited to:

- Allergy testing
- Infertility Services (Once diagnosed, treatment is not covered)
- Occupational therapy
- Physical therapy
- Pre-Surgery/Pre-admission Testing
- Reconstructive services
- Speech therapy
- Health professionals that assist in surgery billing for services
- Treatment of TMJ

No Precertification on file

If claims are not pre-certified, they will be denied for no Precertification. Once information is received, claims can be re-opened based on medical information provided when received within the Appeals timeframe.

Not Medically Necessary

Any services or days determined to not be Medically Necessary will not be covered.

Late Notice Penalty Post-Service Review

For In-Network Providers, late notice penalties do not apply to Members.

For Out-of-Network Providers, the Member late notice penalty is 50% of the Maximum Allowed Amounts for Covered Services.

VOLUNTARY CLINICAL PROGRAMS & RESOURCES

AIM Imaging Cost & Quality Program

The Plan has selected this innovative Imaging Cost & Quality Program for Members through AIM Specialty Health. This Program provides you with access to important information about imaging services you may need. If you need an MRI or a CT scan, it is important to know that costs can vary depending on where you receive the service. Sometimes the difference is significant. The cost can range anywhere from $300 to $3000 (a higher price doesn't guarantee higher quality). When your Benefits require you to pay a portion of this cost (Deductible or Co-insurance), where you go can make a big difference in your out-of-pocket costs.

This is where the AIM Imaging Cost & Quality Program comes in. AIM does the research for you to help you find the right location for your MRI or CT scan. Here is how the Program works:

- Your Doctor refers you to a radiology Provider for an MRI or CT scan.
- AIM will work with your Doctor to help make sure that you are receiving the right test – using evidence-based guidelines.
- AIM reviews the Referral to see if there are other Providers in your area that are high quality, but at a lower price.
- If AIM finds another Provider that meets the quality and price criteria, AIM will contact you.
- You have the choice – you can see the radiology Provider your Doctor referred OR you can choose to see a Provider that AIM chooses for you. AIM will help you schedule an appointment with the new Provider.

The AIM Imaging Cost & Quality Program gives you the opportunity to reduce your health care expenses by selecting high quality, lower cost Providers or locations. No matter which Provider you choose, there is no effect on your health care Benefits. However, if you use AIM Imaging Cost & Quality Program you may lower your out-of-pocket expenses. This information is provided to you regarding this program to help you make informed choices about where to go when you need this type of medical care.

Individual Case Management

Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Anthem's programs coordinate Benefits and educate Members who agree (at no cost) to take part in the Case Management Program to help meet their health-related needs. Case Management programs are confidential and voluntary.

If you meet program criteria and agree to participate, Anthem will assist the Member to meet their identified health care needs. This is reached through contact and teamwork with Members and/or their chosen representative, treating Doctor(s), and other Providers.

In addition, Anthem may help with coordinating care with existing community-based programs and services to meet Members' needs. This may include giving the Member information about external agencies and community-based programs and services.

24/7 Nurse Line

The 24/7 Nurse Line is available by phone 24 hours a day via a toll-free number at 866-787-6361. You will receive instant health care information. Also registered nurses can talk with you about your general health issues and help you determine if you can treat your issue at home, if you need to make an appointment to see your doctor or if you should head to urgent care or the emergency room. Consult with registered nurses on the 24/7 Nurse Line.

Participate in the Personal Health Coach program

If you or another covered family member have certain conditions, the Personal Health Coach can help you better manage your health and follow your doctor's care plan.

Specific conditions include, but are not limited to:

- Asthma: pediatric and adult
- Diabetes pediatric and adult
- Chronic obstructive pulmonary disease
- Heart failure
- Coronary artery disease
- Cancer
- Low Back Pain
- Vascular disease

They can also help you:

- Enroll in the Disease Management (DM) Pharmacy Co-Insurance Waiver Program
- Develop a plan of care so you can better manage your medical condition
- Choose the medical services that are best for you
- Get help setting appointments for routine checkups and exams (preventive care)
- Talk about a diagnosis you got from a doctor and the treatment options you have
- Coordinate your health care benefits before, during, and after a hospital stay

It's easy to connect. SHBP Members can call 866-901-0746. This program is available between 8:00 am to 6:00 pm ET, Monday through Friday. Everything you talk about is confidential.

Future Moms

Future Moms offers helpful tools during your pregnancy. You can consult with a Personal Health Maternity Nurse by phone via a toll-free number at 866-901-0746, option 2. You will receive support during your pregnancy, screening for risk of depression or early delivery, and more. You may also receive *The Mayo Clinic Guide to a Healthy Pregnancy* book by participating in this program.

Also for Members who sign up on www.livehealthonline.com will receive a lactation video and postpartum support for mothers at no additional cost.

Disease Management (DM) Pharmacy Co-Insurance Waiver Program

Anthem Blue Cross and Blue Shield (Anthem) and CVS Caremark have a Disease Management (DM) Pharmacy Co-Insurance Waiver Program. Pharmacy co-insurance for certain prescription drugs will be waived for Members who actively participate in this program. The goal is to encourage Members to actively work on managing their condition and their overall health.

All Members enrolled in the Gold, Silver or Bronze HRA options who are diagnosed with one or more of the following four conditions are eligible to participate in this program:

- Diabetes
- Coronary Artery Disease (CAD)
- Asthma
- Agents for Chemical Dependency

Members must actively participate in a Disease Management program, as confirmed by the Anthem Personal Health Coach (PHC), and complete the following:

- ✓ Complete the Health Information Profile (assessment) with an Anthem Personal Health Coach.
- ✓ Complete the Sharecare RealAge Test (Sharecare is the Wellness Program Administrator providing Lifestyle Management Coaching to SHBP Members. The RealAge Test is a confidential questionnaire that will take the Member about 10 minutes to complete).
- ✓ Actively participate in scheduled coaching calls with an Anthem Personal Health Coach (minimum one call each calendar month).

If you have one of these conditions and are interested in participating in the Personal Health Coach Program and want to learn more about how to qualify, please call the Anthem Member Services at 855-641-4862.

WHAT IS COVERED

This Section gives additional detail on many of the Covered Services outlined in the “Schedule of Benefits” Section table. Your Covered Services are subject to all the terms and conditions listed in this SPD, including, but not limited to, Benefit Maximum, Deductibles, Co-insurance, Exclusions and Medical Necessity requirements. Be sure to read the "How Your Medical Plan Works" Section for more information on your Plan’s rules. The “What’s Not Covered” Section describes important details on Excluded Services. The Section “Getting Approval for Benefits” describes the processes used to determine if a request is a Covered Service.

Please note that several Sections may apply to your claims as noted above. For example, if you have a 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 for all services provided.

Additional details regarding Covered Services are described below:

Allergy Services

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

Ambulance Services (Air, Water, and Ground)

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick /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.
- For ground ambulance, you are taken:
  - From your home, the scene of accident or medical Emergency to a Hospital;
  - Between Hospitals, including when Anthem requires you to move from an Out-of-Network Hospital to an In-Network Hospital.
  - 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 Anthem requires you to move from an Out-of-Network Hospital to an In-Network Hospital.
  - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews. 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. You must be taken to the nearest Facility that can give care for your condition. In certain cases, Anthem may approve Benefits for transportation to a Facility that is not the nearest Facility.

When using an air ambulance, Anthem reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider selected, the Out-of-Network Provider may bill you for any charges that exceed the Maximum Allowed Amount.

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 which include, but are not limited to, trips to a:

- Doctor’s office or clinic;
- 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 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 the first Hospital cannot give you the medical services you need. Certain specialized services are not available at some Hospitals such as burn care, cardiac care, trauma care, and critical care. 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 Expansion
Your Plan includes coverage for the treatment of neurological deficit disorders as required by Law. Coverage is limited to medically necessary Applied Behavioral Analysis (ABA) for the treatment of Autism Spectrum Disorder (ASD). Applicable Deductibles and/or Co-insurance may apply to all covered services.

Cardiac Rehabilitation
Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.

Note: The Benefit Maximum for cardiac therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.

Chemotherapy
The treatment of an illness by chemical or biological antineoplastic agents. See the Section "Drugs Ordered and Administered by a Medical Provider" for more details.

Chiropractic Services / Osteopathic Manipulation Therapy
Benefits are available for chiropractic treatments (20 visits per Benefit Period) provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations, and treatment.

Note: Chiropractic Services and 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.

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

Benefits are limited to the following trials:

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

d. The Centers for Medicare & Medicaid Services.
e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
g. Any of the following in subsections below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
    i. The Department of Veterans Affairs
    ii. The Department of Defense
    iii. The Department of Energy

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

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

Your Plan may require you to use an In-Network Provider to maximize your Benefits. When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trial services that are not part of approved clinical trials will be reviewed according to Anthem's Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide Benefits for the following services and reserves the right to exclude any of the following services:

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

Cancer Clinical Trial Programs for Children
Covered Services include routine patient care costs incurred in connection with the provision of goods, services, and Benefits to Members who are Dependent children in connection with approved clinical trial programs for the treatment of children's cancer. Routine patient care costs mean those Medically Necessary costs as provided in Georgia law (O.C.G.A. § 33-24-59.1).

Dental Services & Oral Surgery (for the treatment of injury or illness)

Note: This Plan provides limited coverage for dental services and oral surgery.

Preparing the Mouth for Medical Treatments
Your Plan includes coverage for dental services to prepare the mouth for surgical procedures that are necessary to repair (or replace) damage done as a result of oral cancer or treatment for oral cancer such as radiation treatment and chemotherapy or as required in preparation for a transplant.

Covered Services in these circumstances include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury
Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. Treatment must begin within 12 months of the injury, or as soon after that as possible to be a Covered Service under this Plan. 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

Oral Surgery
Note: This Plan provides limited coverage for certain oral surgeries. Many oral surgical procedures are not covered by this medical Plan.

Benefits are also limited to certain oral surgeries including:

- Reconstructive surgical procedures (including dental implants) for the repair of sound, natural teeth or tissue that were damaged as a result of oral cancer or treatment for oral cancer such as chemotherapy or radiation treatment and other cancer related treatments with prior approval by the Precertification unit.
- 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 above "Dental Services"
- Treatment of non-dental lesions, such as removal of tumors and biopsies
- Incision and drainage of infection of soft tissue (except for odontogenic cysts or abscesses are not covered)
- Removal of only fully impacted wisdom teeth

Diabetes Equipment, Education, and Supplies, and Eye Exams
Covered Services for the treatment of diabetes include medical supplies, services, equipment, and diabetes self-management education programs. Benefits are also provided for diabetic retinal eye exams.

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 additional information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" in this Section and in "What's Covered" Section. For information on Prescription Drug coverage, please refer to the "Outpatient Prescription Drug Rider" in this SPD.

Diagnostic Services
Your Plan includes benefits for tests or procedures to find or to check a condition when specific symptoms

exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission.

Benefits include the following services:

Diagnostic Laboratory and Pathology Services

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
- Tests ordered before a surgery or hospital admission

Other 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

Note: The list of other imaging services may change as medical technologies change.

Dialysis / Hemodialysis & Specialty Care Physician

Evaluation and Management of acute renal failure and chronic (end-stage) renal disease, including treatment by 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 and home dialysis and training for you and the person who will help you with home self-dialysis.

Drugs Administered and Billed by a Provider as a Medical Service

Your Plan covers Drugs when these are administered to you as part of a Doctor's visit, home care visit, or at an outpatient Facility when your Provider bills under the medical benefits. This includes drugs for infusion therapy, chemotherapy, certain specialty drugs, blood products, and office-based injectables. Certain drugs require Precertification or Prior Approval.

Note: Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by Anthem. The Prescription Drug Benefits which include retail, home delivery and specialty drug programs are administered by CVS Caremark. See refer to the "Outpatient Prescription Drug Rider" in this SPD.

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

Durable Medical Equipment and Medical Devices

Your Plan includes Benefits for durable medical equipment and medical devices when the equipment meets the following criteria: is meant for repeated use and is not disposable; is used for a medical purpose and is of no further use when medical need ends; is meant for use outside a medical Facility, is only for use of the

patient; is made to serve a medical use; and is ordered by a Provider.

Medically necessary Covered Services include:

- The 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)
- Continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by Anthem. 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.
- The 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
- Cochlear implants
- Breast pumps (as described in the “Preventive Care” Section)
- Medical equipment and medical supplies for the treatment of diabetes
- Hearing aids (as described in the “Schedule of Benefits” Section)

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

Orthotics
Benefits are available for certain types of orthotics (braces, boots, and 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 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.

Medically Necessary Covered Services include:

- The fitting, adjustments, repairs and replacements of prosthesis
- 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
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care
- Restoration prosthesis (composite facial prosthesis)
- Wigs needed after cancer/chemotherapy treatment, limited to the $750 lifetime maximum shown in the “Schedule of Benefits” Section

Blood and Blood Products
Your Plan also includes coverage for the administration of blood products (unless they are received from a community source, such as blood donated through a blood bank).

Emergency Care Services

Emergency Services
Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined on the following page.

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

Emergency Care
"Emergency Care" means a medical examination done in the Emergency Department of a Hospital and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It also includes any further medical examination(s) and/or treatment(s) required to stabilize the patient.

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

Medically Necessary services will be covered whether you receive 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.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor call Anthem as soon as possible. Anthem will review your care & determine if the Hospital admission and length of stay is a covered service. See "Getting Approval for Benefits" for more details. If you or your Doctor do not call Anthem, you may have to pay for services that are determined to not be 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 Anthem agrees to cover it as an Authorized Service.

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 is not 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.

Home Care Services
Benefits are available for Covered Services performed by a Home Health Care Agency or other 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
- Therapy Services (except for Manipulation Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment
- Home health services. Home health services are limited to skilled nursing or therapy services provided in the home that are prescribed to achieve specific health care goals. Covered home health services must be provided by professional health personnel such as registered nurses, licensed practical nurses,

occupational therapists, physical therapists, speech pathologists or audiologists. The prescribing provider must update the home health treatment plan at least once every 30 days to define the continued need for skilled intervention. Home health services do not include custodial care. Custodial care generally provides assistance in performing activities of daily living (e.g., assistance walking, transferring in and out of bed, bathing, dressing, using the toilet, preparation of food, feeding and supervision of medication that usually can be self-administered). Custodial care essentially is personal care that does not require the attention of trained medical or paramedical personnel.

- Home Infusion Therapy– includes Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes: Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See Section “Drugs Administered and Billed by a Provider as a Medical Service” for more details.

Hospice Care

Your Doctor and Hospice medical director must certify that you are terminally ill and probably have less than 12 months to live. Your Doctor must agree to Hospice care 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 Anthem upon request.

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

Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse
- Social services and counseling services from a licensed social worker
- Nutritional support, such as intravenous feeding and feeding tubes
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, (both before and after the Member’s death). Bereavement services are available to surviving Members of the immediate family for one year after the Member’s death. Immediate family means your spouse, children, stepchildren, parents, brothers and sisters.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be 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. A Covered Transplant Procedure is defined as the determination by Anthem, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions (including necessary acquisition procedures, mobilization, harvest and storage). It also, includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Anthem has a Centers of Excellence (COE) Network selected to give specific services to Members. Members must use a Blue Distinction Center for Transplants (BDCT) or one of the Center of Medical Excellence (CME).

Transplant Network facilities to receive benefits for transplant services:

- **Blue Distinction Center for Transplant (BDCT)** The Blue Distinction Centers for Specialty Care℠ is a program administered by the Blue Cross and Blue Shield Association that identifies quality providers for transplant services nationwide. Each Center has been selected through a rigorous evaluation of clinical data that provides insight into the facility's structures, processes, and outcomes of care.
- **Centers of Medical Excellence (CME)** The CME designation is awarded by Anthem to those programs meeting the participation requirements for Anthem's transplant network and all other future specialty networks developed by Anthem. Each Center has been selected through a rigorous evaluation of clinical data that provides insight into the facility's structures, processes, and outcomes of care.

Precertification and Prior Approval for Transplant Services

Precertification and Prior Approval are required (except for kidney & cornea) before the Plan will cover Benefits for a transplant. To maximize your Benefits, call Anthem's Transplant Department as soon as you think you may need a transplant, before evaluation and/or workup, and to talk about your benefit options. The Transplant department will help you maximize your Benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, or Exclusions apply. Call the Member Services phone number on your Anthem Member ID Card and ask for the transplant coordinator. Your Doctor must certify, and Anthem must agree, that the transplant is Medically Necessary. Your Doctor should send a written request for Precertification to Anthem as soon as possible to start this process. Failure to obtain Precertification will result in a denial of Benefits.

Even if you are given a prior approval for the Covered Transplant Procedure, you or your Provider must call the Transplant Department for Precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Note: There are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest 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 diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity, and a coverage determination made. In an approval determination for HLA testing, donor search and/or harvest and storage; however, is NOT an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Donor Benefits for Transplant Services

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 for Transplant Services

The Plan will cover the cost of reasonable and necessary travel costs (when you get prior approval), and need to travel more than seventy-five (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, with 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 to Anthem when claims are filed. Call Anthem 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, but not to exceed $10,000 per transplant episode. The Internal Revenue Code can be found at www.irs.gov that also lists the standard mileage rate for use of an automobile (1) for medical care described in § 213.

Non-Covered Services for transportation and lodging for transplant services 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 Anthem), 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, and meals.

NOTE: Travel and Lodging reimbursement is also available for eligible members when receiving cancer treatment at an eligible Cancer Resource Service Center of Excellence* (COE). The member's home address must be at least 75 miles from the COE (200 miles for airfare). All eligible expenses are reimbursed after the Expense Forms have been completed and submitted with the appropriate receipts. All other guidelines follow those outlined above under Transportation and Lodging for Transplant Services.

Inpatient Facility 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 Anthem. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay
- Meals, special diets
- General nursing services

Benefits for ancillary services include:

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

Inpatient Professional Services
Covered Services include:

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

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

- Professional and Facility services for childbirth in a Facility or the home, including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal and postnatal services;
- Medically Necessary fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed

If you are pregnant on your effective date and your Provider is not In-Network, you must fill out a Continuation of Care Request Form and send it to Anthem to have covered services processed at the In-Network level. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate postpartum period. If you change doctors during your pregnancy, the prenatal and postnatal fees will be billed separately.

Note about Maternity Admissions: Under federal law, the Plan may not limit Benefits for any Hospital length of stay for childbirth, for the mother or newborn to: less than 48 hours after vaginal birth; or less than 96 hours after a cesarean section (C-section). However, federal law, as a rule, does not stop the mother's or newborn's attending Provider (after consulting with the mother), from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, 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. Please see "Preventive Care" Section for regarding sterilization services for further details.

Abortion Services
Benefit includes an abortion only when the life of the mother is at risk.

Infertility Services
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). Diagnostic services are covered to rule out a diagnosis, but once diagnosed; treatment of infertility is not covered. This Plan does not offer any form of infertility treatment.

Note: Coverage for Infertility drugs may be approved for a medical diagnosis not related to infertility treatment when the medical diagnosis meets the definition of a Covered Service and is not an Experimental, Investigational, or Unproven Service.

Mental Health and Substance Abuse Services
Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient Benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification or outpatient facility, such as partial hospitalization programs and intensive outpatient programs.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital and

office visits.

You can get Covered Services from the following Providers:

- Psychiatrist
- Psychologist
- Neuropsychologist
- Licensed clinical social worker (L.C.S.W.)
- Mental health clinical nurse Specialist
- Licensed marriage and family therapist (L.M.F.T.)
- Licensed professional counselor (L.P.C)
- Any agency licensed to provide these services when they must be covered by law

Office Visits and Physician Services

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

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.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that a Doctor visit in the home is different than the "Home Care Services" benefit described earlier in this SPD.

Retail Health Clinic 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.

Online Visits (LiveHealth Online)
When available in your area, your coverage will include medical and behavioral online visits from a LiveHealth Online contracted Provider through your smartphone, tablet, or computer. Medical online visits are available 24/7 without an appointment. LiveHealth Online Psychology appointments are available 7 days a week, 7 a.m. to 11 p.m. for adults and children ages 10 and older and are subject to appointment availability. See the Schedule of Benefits for applicable Co-insurance. Visit www.livehealthonline.com or download the free app.

Please note that LiveHealth Online providers are not able to prescribe controlled substances and lifestyle drugs. Prescriptions written must meet state regulations and SHBP formulary and prior authorization guidelines.

Also available to Members who sign up for the Anthem Future Moms program can receive a lactation video and postpartum support for mothers at no additional cost.

NOTE: Online visits are not covered from Providers other than those contracted with LiveHealth Online. LiveHealth Online can be used for common health conditions such as the flu, cold, sinus infections, stress, and family health questions; however, for an emergency, call 911.

Non-Covered Services include but are not limited to communications used for:

- Reporting normal lab or other test results.
- Office appointment requests.
- Billing, insurance coverage or payment questions.
- Requests for referrals to Physicians outside the online care panel.
- Benefit Precertification.

- Physician to Physician consultation.

Outpatient Facility Services
Your Plan includes Covered Services in an:
- Outpatient Hospital.
- Freestanding Ambulatory Surgical Facility.
- Mental Health / Substance Abuse Facility.
- Other Facilities approved by Anthem.

Benefits include Facility and related (ancillary) charges, when proper, such as:
- Surgical rooms and equipment.
- Prescription Drugs including specialty drugs.
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Physical Medicine Therapy Services (Physical, Occupational and Speech Therapy)
For Early Intervention Services, 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 also 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 "Schedule of Benefits" for physical, speech and occupational therapies.

For all other Members (e.g., those six (6) and older, or who do not qualify for the Benefits above), Benefits are provided only if the physical, speech or occupational therapy are Medically Necessary and will result in a practical improvement in the level of functioning within a reasonable period of time.

The limit for physical therapy, speech therapy, and occupational therapy will not apply when you receive this care as part of Hospice Care or at an Inpatient Facility.

Benefits for physical, speech or occupational therapy as detailed below are allowed up to the maximum visits listed in the "Schedule of Benefits". Covered Services include:

- Physical therapy – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.

  Note: Physical Therapy benefits may be extended beyond 40 visits for children up to age 19 with Congenital Anomalies. The child will also have to be enrolled in case management and meet medical necessity criteria.
- 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 swallowing skills or communication to correct a speech impairment.
- 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.

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. Preventive care services

must meet the requirements of federal and state law. Certain Preventive care services are covered with no Deductible or Co-insurance when you use an In-Network Provider and the service is properly coded as preventive care. That means the Plan covers 100% of the Maximum Allowed Amount, Deductible, and Co-insurance for certain services may still apply for covered services performed prior to rendering of a preventative care service. For example, the pre-operative colonoscopy visit Deductible and Co-insurance may apply.

Covered Services include the following:

1. 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
   - Child and adult obesity
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
4. Preventive care and screening as listed in the guidelines supported by the Health Resources and Services Administration, including:
   - Contraceptives, sterilization procedures and counseling.
   - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.
   - Gestational diabetes screening
5. The following services required by state and federal law:
   - Lead poisoning screening for children
   - Routine mammograms
   - Routine colorectal cancer examination and related laboratory tests
   - Chlamydia screening
   - Ovarian surveillance testing
   - Pap smear
   - Prostate screening
   - 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
     - Varicella
     - Additional immunizations will be covered per federal law, as indicated earlier in this Section (excluding travel immunizations)

You may call Anthem Member Services at the number on your Member ID 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

Note: Services for an illness or injury including diagnostic services are not covered under the Preventive benefit.

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.

Rehabilitation Services

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

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 airway 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, and incentive spirometers, broncho-pulmonary drainage and breathing exercises.

Pulmonary Rehabilitation – Includes outpatient short-term respiratory care to restore your health after an illness or injury.

Note: The Benefit Maximum for cardiac therapy will not apply when you get that care as part of the Hospice Care or the Inpatient Facility Services benefit.

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 and Skilled Nursing Facilities Out-of-Network are not Covered Services.

Surgery

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

Covered Services include:

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

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. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: See the “Women’s Health and Cancer Rights Act of 1998” in the “Additional Federal Notices” Section for details regarding mastectomy including reconstruction.

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.

Note: 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).

Urgent Care Services
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, but are not limited, to earache, sore throat, and fever.

Benefits are available for urgent care such as:

- X-ray services
- Tests such as flu, urinalysis, pregnancy test, rapid strep
- Lab services
- Stitches for simple cuts
- Draining an abscess

Vision Services
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.

WHAT IS 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. **Abortion** Services, supplies, Prescription Drugs, and other care provided for elective voluntary abortions and/or fetal reduction surgery. This Exclusion does not apply to abortions performed to save the life of the mother.

2. **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond the Medical Claims Administrator's control, Anthem will make a good faith effort to give you Covered Services. Anthem 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.

3. **Administrative Charges**
   - Charges for the completion of claim forms,
   - Charges to get medical records or reports,
   - 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.

4. **Alternative/Complementary Medicine** Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
   - Acupuncture,
   - Holistic medicine,
   - Homeopathic medicine,
   - Hypnosis,
   - Aromatherapy,
   - Massage and massage therapy,
   - Reiki therapy,
   - Herbal, vitamin or dietary products or therapies,
   - Naturopathy,
   - Thermography,
   - Orthomolecular therapy,
   - Contact reflex analysis,
   - Bioenergial synchronization technique (BEST),
   - Iridology-study of the iris,
   - Auditory integration therapy (AIT),
   - Colonic irrigation,
   - Magnetic innervation therapy,
   - Electromagnetic therapy,
   - Neurofeedback / Biofeedback.

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

6. **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services.

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

8. **Chiropractic Services / Osteopathic Manipulation Therapy** Services include, but are not limited to:
   - Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning, and prevents loss of that functioning, but which does not result in any additional improvement.
   - Nutritional or dietary supplements, including vitamins
   - Cervical pillows
   - Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.
   - Manipulation Therapy is not covered when given in the home

9. **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. However, if complication is an unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition a medical necessity review will be performed to determine benefits. Examples of a complication to warrant a medical necessity review are infections or blood disorders following a Cosmetic Procedure.

10. **Contraceptives** Non-prescription contraceptive devices, unless required by law.

11. **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 a body area that has been altered by illness or trauma.

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

13. **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.

14. **Custodial Care, Convalescent Care and Rest Cures**. This Exclusion does not apply to Hospice services.

15. **Dental Treatment** 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 SPD);
    - Services to help dental clinical outcomes.

    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 those services required by the law to be covered.

16. **Dental Services** Dental services not described as Covered Services in this SPD.

17. **Donor Breast Milk**

18. **Educational Services** or supplies for teaching, vocational, or self-training purposes, including Applied Behavior Analysis (ABA), except as listed in this SPD for prior approved ABA for Autism Spectrum Disorders.

19. **Experimental or Investigational Services or supplies** that are found to be Experimental or

Investigational. This also applies to services related to Experimental/Investigational services, whether you get them before, during, or after you get the Experimental/Investigational service or supply.

The fact that a service or supply is the only available treatment for a condition will not make it eligible for coverage if Anthem deems it to be Experimental / Investigative.

20. **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.

21. **Eye Exercises, Orthoptics and vision therapy.**

22. **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.

23. **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.

24. **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:

    - Cleaning and soaking the feet.
    - Applying skin creams to care for skin tone.
    - Other services that are given when there is not an illness, injury or symptom involving the foot.

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

26. **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

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

    If Worker's Compensation Benefits are not available to you, 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.

28. **Gynecomastia** Treatment of benign gynecomastia (abnormal breast enlargement in males).

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

30. **Home Care**
    - 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.
    - Private duty nursing.
    - Food, housing, homemaker services and home delivered meals.

31. **Immunizations** necessitated by travel.

32. **Infertility Treatment** Testing or treatment related to infertility except for diagnostic services and procedures to correct an underlying medical condition. Non-covered service includes 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). Fertility treatments such as artificial insemination and in-vitro fertilization, egg and sperm storage/preservation for future pregnancy. Other Infertility procedures not specified in this SPD are not Covered Services.

33. **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.

34. **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.

35. **Medicare** Services for which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if you had applied for Parts A and/or B, except, as listed in this SPD or as required by federal law, as described in the section titled "Medicare" in the “General Provisions” section. If you do not enroll in Medicare Part B, the Medical 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. For Medicare Part D the Medical Claims Administrator will calculate benefits as you had enrolled in the Standard Basic Plan

36. **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.

37. **Non–Covered Providers** Examples of Non-Covered Providers include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

38. **Non-Medically Necessary Services** As determined by Anthem. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.

39. **Nutritional Formulas or Dietary Supplements** Nutritional/Enteral formulas including infant formula, dietary and electrolyte supplements. This exclusion includes, but is not limited to, nutritional formulas and supplements that you can buy over the counter and those you can get without a written prescription or from a licensed pharmacist.

    Enteral feedings are not covered except if it is the sole source of nutrition or for inborn errors of metabolism except for those pre-approved through Anthem case management and meet Anthem’s Clinical Guideline for coverage.

40. **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 for the extraction of fully impacted wisdom teeth.

41. **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).

42. **Prescription Drugs** Prescription Drugs received from a Retail or Home Delivery (Mail Order) Pharmacy. Pharmacy Benefits are administered separately. See the “Prescription Drug Pharmacy Benefits” table in this Section and the “Outpatient Prescription Drug Rider” Section of the SPD for more information.

43. **Private Duty Nursing** Private Duty Nursing Services.

44. **Prosthetics** for sports or cosmetic purposes.

45. **Religious, marital and sex counseling**, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

46. **Routine Physical Exams** Physical exams required for enrollment in any insurance program, as a condition of employment, for licensing, or for school activities.
47. **Sex Change** Services and supplies for a sex change, gender reassignment and/or the reversal of a sex change.
48. **Sexual Dysfunction** Services or supplies for male or female sexual problems.
49. **Stand-By Charges** Stand-by charges of a Doctor or other Provider.
50. **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.
51. **Surrogate Mother 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).
52. **Tobacco Cessation Programs** to help you stop using tobacco if the program is not affiliated with Anthem or Sharecare (SHBP Wellness Program Administrator).
53. **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
54. **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
55. **Vision Services** Vision services not described as Covered Services in this SPD.
56. **Weight Loss Programs**, whether or not under medical supervision. This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
57. **Weight Loss Surgery** Bariatric surgery. Non-covered services includes but are 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.

MEDICAL CLAIMS PAYMENT

This Section describes how the Medical Claims Administrator, Anthem, 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 SPD.

Maximum Allowed Amount

This Section describes how Anthem determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on the 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 Covered Services:

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

When you receive Covered Services from an eligible Provider, Anthem, 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 Anthem has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, a Provider may submit a 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 Plan or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with Anthem. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for the Plan is the rate the Provider has agreed to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as your 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 Co-insurance. Please call Member Services for help in finding an In-Network Provider or visit www.anthem.com/shbp.

Providers who have not signed any contract with Anthem and are not in any of Anthem's networks are Out-of-Network Providers, (subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers).

For non-emergency Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1. An amount based on Anthem Out-of-Network fee schedule/rate, which Anthem has established in its discretion, which Anthem reserves the right to modify from time to time, after considering one or more of the following: (i) reimbursement amounts accepted by like/similar Providers contracted with Anthem; (ii) reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, and (iii) reimbursement and utilization data.
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually.
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.
4. An amount negotiated by Anthem or a third-party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
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; or
6. An amount that is otherwise assigned and/or required by State Mandate.

Note: Providers who are not contracted for your Plan, but are contracted for Anthem's indemnity product are considered Non-Preferred. In your Plan, the Maximum Allowed Amount for services from these Providers will be one of the five (5) methods shown above unless the contract between Anthem and that Provider specifies a different amount. In this case, these 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 bill and collect for the amount of the Provider's charge that exceeds the Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will result in lower out-of-pocket costs to you.

Member Services 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 Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim

will be based on the services rendered at the time of service and the claim submitted by the Provider.

Member Cost Share
For Covered Services you will be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible and Co-insurance).

Your cost share amount and Out-of-Pocket Maximum 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. See "Schedule of Benefits" Section in this SPD for your cost share responsibilities and limitations, or call Member Services to learn how this Plan's Benefits or cost share amounts will vary by the network status of the 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 have a higher cost sharing amount when you use an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Outpatient 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 may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services for Out-of-Network Providers
In some circumstances, such as when there is no In-Network Provider available for the Covered Service, your plan may authorize the In-Network cost share amounts (Deductible, and/or Co-insurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In these circumstances, you must contact Anthem prior to receiving the Covered Service. You may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Your 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 Anthem until after the Covered Service is rendered. Please contact Member Services to obtain authorization or to request information on Authorized Services.

Claims Review
Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Please contact Member Services for details.

Notice of Claim & Proof of Loss

After you get Covered Services, Anthem must receive written notice of your claim within twelve (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, Anthem 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 Anthem did not receive your claim within ninety (90) calendar days, but it is sent in as soon as reasonably possible and within one year after the ninety (90) day period ends (i.e. within fifteen (15) months), you may still be able to get Benefits.

Note: Additional or missing information on claims initially received as stated above can be submitted to Anthem up to twenty-four (24) months after you receive Covered Services.

Your claim will be processed and any payment of claims will be made as soon as possible following receipt of the claim. Any Benefits payable for Covered Services will be paid within fifteen (15) business days for electronic claims; or thirty (30) calendar days for paper claims (unless more time is required because of incomplete or missing information). In this case, you will be notified within fifteen (15) business days for electronic claims; or thirty (30) calendar days for paper claims of the reason for the delay and will receive a list of all information needed to continue processing your claim. After this data is received, Anthem has fifteen (15) business days to complete claims processing for electronic claims; or thirty (30) calendar days for paper claims. Any portion of your claim that does not require additional information will be processed according to the timeframes outlined above. Anthem shall pay the interest at the rate of twelve percent (12%) per year by Anthem to you or the assigned Provider if it does not meet these requirements.

Medical Claim Forms

Medical claim forms will usually be available from most Providers. If forms are not available, visit Anthem website at www.anthem.com/shbp or call Member Services and ask for a claim form to be sent to you. If you do not receive the claim form, written itemization and description of services rendered may be submitted without the medical claim form. The same information that would be given on the claim form must be included in the written notice of claim.

This includes:

- Member ID
- Name of patient
- Patient's relationship with the Covered Person
- 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, you will be responsible for any charge for services.

Payment of Benefits

Anthem may make benefit payments directly to In-Network Providers for Covered Services. If you use an Out-of-Network Provider, Anthem may make benefit payments to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to an Alternate Recipient (for any child of a Covered Person who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Plan), or that person's custodial parent or designated representative. Once a Provider performs a Covered Service, Anthem will not honor a request to withhold payment of the claims submitted. 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.

Inter-Plan Programs and Out-of-Area Services

Blue Cross and Blue Shield Healthcare Plan (BCBSHP) has relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain Covered Services outside of BCBSHP's 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 BCBSHP and other Blue Cross and Blue Shield Licensees. Typically, when accessing care outside BCBSHP's service area, you will obtain care from other Providers that have a contractual agreement (i.e., "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 non-participating Providers. BCBSHP's payment practices in both instances are described below.

BCBSHP covers only limited healthcare services received outside of BCBSHP corporate parent's Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include Emergency Care and

urgent care obtained outside the geographic area BCBSHP's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your Primary Care Physician ("PCP").

BlueCard® Program

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

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The participating healthcare Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Cost share amount.

Emergency Care Services: If you experience a Medical Emergency while traveling outside the BCBSHP Service Area, go to the nearest Emergency Care Facility or Urgent Care Center.

Whenever you access covered healthcare services outside BCBSHP's 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 BCBSHP.

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 BCBSHP 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.

You will be entitled to Benefits for healthcare services that you accessed either inside or outside the geographic area BCBSHP 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 BCBSHP serves, even though you might not otherwise have been entitled to Benefits if you had received those healthcare services inside the geographic area BCBSHP 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 Providers outside Anthem's Service Area Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating Providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating 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, Anthem may use other payment bases, such as billed covered charges, the payment the Plan would make if the healthcare services had been obtained within Anthem'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 non-participating 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.

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 Allowed Amount. Call the Anthem Member Services on your Member ID Card or go to www.anthem.com/shbp for more information about such arrangements.

COORDINATION OF BENEFITS WHEN MEMBERS ARE INSURED UNDER MORE THAN ONE PLAN

If you, your spouse, or your Dependents have duplicate 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 Maximum Allowed Amount or the contracted amount.

Allowable amount means any necessary, reasonable and customary expense where at least a portion of which is covered under at least one of the programs covering the person for whom the claim is made. The claim determination period is the Benefit Period.

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

Claim Determination Period means a Benefit Period Year. However, it does not include any part of a year during which you have no coverage under This Plan or any part of a year before the date this "Coordination of Benefits" provision or a similar provision takes effect.

Plan, for the purposes of this Section, means any of the following that provides Benefits or services for, or because of, medical or dental care or treatment:

1. 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.
2. 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 excess to those of any private insurance program or other non-governmental program.
3. "No-fault" and group or group-type "fault" automobile insurance policies or contracts.

Each contract or other arrangement for coverage under 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.

This Plan means the part of this Plan that provides Benefits for Covered Services.

Primary Plan/Secondary Plan means the "Order of Benefit Determination Rules" states whether This Plan is a Primary Plan or Secondary Plan in relationship to another Plan covering you.

- When This Plan is the Secondary Plan, the Benefits are determined after those of the other plan and may be reduced because of the other plan's Benefits.

- When This Plan is the Primary Plan, the 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 duplicate coverage, claims will be paid as follows:

- **Automobile Insurance** - Medical Benefits available through automobile insurance coverage will be determined before This Plan.
- **Non-Dependent/Dependent** - The Benefits of the plan which covers the person as a Covered Person (other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
- **Dependent Child/Parents Not Separated or Divorced** - Except as stated below, when this plan and another plan cover the same child as a Dependent of different persons, called "parents":

  1. The Benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year.
  2. If both parents have the same birthday, the Benefits of the plan which covered the parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

  However, if the other plan does not have the rule described above, but instead has a rule based on the gender of the parent, and as a result, the plans do not agree on the order of Benefits, the rule in the other plan will determine the order of Benefits.

- **Dependent Child/Parents Separated or Divorced** - If two or more plans cover a person as a Dependent child of divorced or separated parents, Benefits for the child are determined in this order:
  1. the plan of the parent with custody of the child;
  2. the plan of the spouse of the parent with custody of the child; and
  3. the plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the company obligated to pay or provide the Benefits of the plan of that parent has actual knowledge of those terms, the Benefits of that plan are determined first. This paragraph does not apply with respect to any claim determination period or plan year during which any Benefits are actually paid or provided before the company has that actual knowledge.

- **Joint Custody** - If the specific terms of a court decree state that the parents shall have joint custody, (without stating that one of the parents is responsible for the health care expenses of the child), the plans covering the child shall follow the order of benefit determination rules outlined above for "Dependent Child/Parents not Separated or Divorced."
- **Active/Inactive Covered Person** - The Benefits of a plan that covers a person as a Covered Person who is neither laid off nor retired (or as that Covered Person's Dependent) are determined before those of a plan that covers that person as a laid-off or retired Covered Person (or as that Covered Person's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of Benefits, this rule is ignored.
- **Longer/Shorter Length of Coverage** - If none of the above rules determine the order of Benefits, the Benefits of the plan which covered a Covered Person or Member longer are determined before those of the plan that covered that person for the shorter time.

Effect on the Benefits of This Plan
This Section applies when, in accordance with the Order of Benefit Determination Rules, This Plan is a secondary plan to one or more other plans. In that event the Benefits of This Plan may be reduced under this Section. Such other plan(s) are referred to as "the other plans" below.

Reduction in This Plan's Benefits
The Benefits of this Plan will be reduced when the sum of:

- the Benefits that would be payable for the Allowable Expenses under This Plan in the absence of this provision; and

- the Benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this provision, whether or not claim is made, exceed those Allowable Expenses in a claim determination period. In that case, the Benefits of this Plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses.

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

Right to Receive and Release Needed Information
Certain facts are needed to apply these rules. Anthem has the right to decide which facts it needs. Anthem may need to get facts from or give them to any other organization or person, as necessary to coordinate Benefits. Anthem need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must provide any facts needed to pay the claim.

Facility of Payment
A payment made under another program may include an amount which should have been paid under This Plan. If it does, Anthem 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, Anthem 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.

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays Benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise.

If you obtain a Recovery, the Plan shall have a right to be repaid from the Recovery in the amount of the Benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of Benefits the Plan paid on your behalf.
- Our right of Recovery shall be limited to the amount of any Benefits paid for covered medical expenses under this Plan, but shall not include non-medical items.

Your Duties:

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.
- We may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized, regardless of whether you have been fully compensated or made whole. No “Made-Whole Doctrine” or “Make-Whole Doctrine,” claim of unjust enrichment, nor any other equitable limitation shall limit our subrogation and reimbursement rights.

MEMBER RIGHTS AND RESPONSIBILITIES

As a Covered 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 Medical Claims Administrator, Anthem, is committed to making sure your rights are respected while paying for Covered Services. That also means giving you access to the Network Providers and the information you need to make the best decisions for your health and welfare. Anthem 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.

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 is 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 Plan, and share your feedback. This includes information on:
  - Anthem's company and services.
  - Anthem's network of Doctors and other health care Providers.
  - Your rights and responsibilities.
  - The rules of your health care plan.
  - The way your Plan works.
- Make a complaint or file an appeal about:
  - Your Plan, or
  - Any care you get, or
  - 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 do not 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.
- Treat all Doctors, health care Providers and staff, your case manager and Personal Health Coach 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.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.
- Give Anthem, 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.

For more information call Anthem Member Services or go to www.anthem.com/shbp.

YOUR RIGHT 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 Medical Claims Administrator, Anthem, follows the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, Anthem'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 Anthem'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).
- 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:

- Anthem's notice will also include a description of the applicable urgent/concurrent review process.
- Anthem may notify you or your authorized representative within seventy-two (72) hours orally and then furnish a written notification.

Mandatory First Level 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. Anthem'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.

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 Anthem's decision, can be sent between Anthem 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 Anthem at the number shown on your Member ID Card and provide at a minimum:

- the Member ID number for 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

- reason 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:

BCBSHP, ATTN: Appeals, P.O. Box 105449, Atlanta, GA 30348-5187

Upon request Anthem 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;
- was submitted, considered, or produced in the course of making the benefit determination;
- 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.

Anthem 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, Anthem will provide you, free of charge, with the rationale.

For Out of State Appeals (Grievances)
You have to file Provider Appeals with the BlueCard Out of State Plan. This means Providers must file Appeals with the same plan to which the claim was filed. Please contact 855-641-4862 to obtain additional information on the Appeal process for BlueCard providers.

How Your Appeal will be Decided
When Anthem considers your appeal, Anthem will not rely upon the initial benefit 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 mandatory 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, 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:** Anthem will notify you of the outcome of the appeal as soon as possible, but not later than seventy-two (72) hours after receipt of your request for appeal.
- **If you appeal any other pre-service claim:** Anthem will notify you of the outcome of the appeal within fifteen (15) days after receipt of your request for appeal.
- **If you appeal a post-service claim:** Anthem will notify you of the outcome of the appeal within thirty (30) 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 Anthem will include all of the information set forth in the above Section "Notice of Adverse Benefit Determination".

Mandatory Second Level Appeals (Grievances)
If you are dissatisfied with the Plan's mandatory first level appeal decision, a mandatory second level appeal

may be available. If you would like to initiate a second level appeal, please write to the address listed above. Second level appeals (Grievances) must be submitted within sixty (60) calendar days of the denial of the first level appeal. You are required to complete a mandatory second level appeal prior to submitting a request for an independent External Review.

Note: The mandatory second level appeal can be bypassed upon request if the initial first level appeal is deemed experimental and investigational. In these situations, the next appeal level can be independent External Review.

External Review

If the outcome of the mandatory first and second level appeals are adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law. You must submit your request for External Review to Anthem within four (4) months of the notice of your final adverse determination.

A request for an External Review must be in writing unless Anthem determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted in the first and second level appeals, as applicable. However, you are encouraged to submit any additional information that you think is important for review.

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

- the Member ID number for 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
- reason the appeal should be processed on a more expedited basis.

Such requests should be submitted by you or your authorized representative to:

BCBSHP, ATTN: Appeals, P.O. Box 105449, Atlanta, GA 30348-5187

This is 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 other means available through applicable state laws.

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, before filing a lawsuit or taking other legal action of any kind against the Plan.

Anthem reserves the right to modify the policies, procedures and timeframes in this Section upon further clarification from the Department of Health and Human Services and Department of Labor.

GENERAL PROVISIONS

Form or Content of SPD
No agent or Covered Person of the Medical Claims Administrator, Anthem, is authorized to change the form or content of this SPD. Such changes can be made only through an endorsement authorized and signed by an officer of Plan Administrator.

Government Programs
The Benefits under this Plan shall not duplicate any Benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payor. If duplication of such Benefits occurs, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to the Plan.

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

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

Medicare
Any Benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor 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, SPD terms, and federal law.

Except when federal law requires the Plan to be the primary payor, 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 Parts B and/or D. Where Medicare is the responsible payor, 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, if you have not enrolled in Medicare Parts B and/or D, Anthem will pay primary Benefits and Covered Person will pay the unsubsidized premium.

Note: You should enroll in Medicare Part B as soon as possible to avoid paying the unsubsidized rates.

Governmental Health Care Programs
Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Plan and receive group Benefits as primary coverage. Also, spouses (regardless of age) of active Employees can remain on the Plan and receive group Benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to your local Social Security Administration office.

Modifications
The Plan Administrator may change the Benefits described in this SPD and the Member will be informed of such changes as required by law. This SPD shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Plan Administrator, or by mutual agreement between Anthem and the Plan Administrator without the consent or concurrence of any Covered Person. By electing medical and Hospital Benefits under the Plan or accepting the Plan Benefits, all Covered Persons legally capable of

contracting, and the legal representatives of all Covered Persons incapable of contracting, agree to all terms, conditions, and provisions hereof.

Not Liable for Provider Acts or Omissions
Neither Anthem nor the Plan Sponsor are responsible for the actual care you receive from any person. This SPD does not give anyone any claim, right, or cause of action against Anthem or the Plan Sponsor based on the actions of a Provider of health care, services, or supplies.

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

Anthem has the authority, in its discretion, to institute from time to time, utilization management, care management or disease management in certain designated geographic areas. These pilot initiatives are part of Anthem's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Members under the Plan. These programs will not result in the payment of Benefits which are not provided in the Plan, unless otherwise agreed to by the Plan Sponsor.

Blue Cross and Blue Shield Healthcare Plan (BCBSHP) of Georgia, Inc.
The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans**,** with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, BCBSHP is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of BCBSHP other than those obligations created under other provisions of the Administrative Services Agreement or this SPD.

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

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

Right of Recovery
Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. In the event the Plan recovers a payment made in error from the Provider, except in cases of fraud, the Plan will only recover such payment from the Provider during the twenty-four (24) months after the date the Plan made the payment on a claim submitted by the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in your explanation of Benefits is the final determination and you will not receive notice of an adjusted cost share amount as a result of such Recovery activity.

Anthem has oversight responsibility for compliance with Provider and vendor contracts. The Plan Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Anthem will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. Anthem may not give you notice of overpayments made by the Plan or you if the Recovery method makes providing such notice administratively burdensome.

Unauthorized Use of Member ID Card
If you permit your Member ID Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Fraud
Fraud is knowingly and willfully defrauding any health care benefit program by misrepresentation of facts resulting in unauthorized benefits, payments or gains to an individual or entity. Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Member's coverage. If you believe you have found fraud, call our fraud hotline at 800-831-8998. Or, you can call the Anthem Member Services number on your Member ID Card.

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

Waiver
No agent or other person, except an authorized officer of the Plan Sponsor, is able to disregard any conditions or restrictions contained in this SPD, 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.

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 Worker's Compensation coverage requirements.

ANTHEM MEDICAL DEFINITIONS

If a word or phrase in this SPD has a special meaning, such as Medical Necessity or Experimental/Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call the Member Services at the number on your Anthem Member ID Card.

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

Ambulatory Surgical Facility
A Facility, with a staff of Doctors, that:
1. Is licensed where required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Appeals (Grievance)
An adverse benefit determination that You have the right to appeal. Please see the "Your Right to Appeal" Section.

Assignment of Benefits (AOB)
A method where the person receiving medical benefits assigns the payment of those benefits to a physician or hospital.

Authorized Service(s)
A Covered Service you get from an Out-of-Network Provider that the Medical Claims Administrator has agreed to cover at the In-Network level. You will have to pay any In-Network Deductible, and/or Co-insurance, that apply, and may also have to pay the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please see Section "Claims Payment" for more details.

Benefits
Your right to payment for Covered Services which are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations, and exclusions of the Plan, including this SPD and any attached Riders and Amendments.

Benefit Period
The length of time that the Plan will cover Benefits for incurred Covered Services. The SHBP is a Calendar Year plan. The Benefit Period starts on January 1 and ends on December 31.

Benefit Period Maximum
The maximum amount 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 Excellence Agreement with the Medical Claims Administrator.

Co-insurance
Your share of the cost for Covered Services that is a percent of the Maximum Allowed Amount. You normally pay Co-insurance after you meet your Deductible. For example, if your Plan lists 20% Co-insurance on medical service, and the Maximum Allowed Amount is $100, your Co-insurance would be $20 after you have met your Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the "Schedule of Benefits" for details. Your Co-insurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Covered Person
Either the Enrolled Member or an Enrolled Dependent but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

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

- Medically Necessary or specifically included as a benefit under this SPD.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigative, excluded, or limited by this SPD, or by any amendment or rider to this SPD.
- Approved by the Medical Claims Administrator before you get the service if 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" in the separate SPD Eligibility and Enrollment Provisions document posted at www.shbp.georgia.gov.

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

Custodial Care
Any type of care, including room and board, that: (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; and (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,
- 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 $1,500, your Plan does not pay until you meet the $1,500 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits" for details.

Dependent
A person who meets all Dependent eligibility requirements as a result of his or her relationship with an Enrolled Member.

Doctor
See definition "Physician."

Effective Date
The date your coverage begins under this Plan.

Employee
The term Employee means a full-time employee of the State of Georgia, the General Assembly or an agency, board, commission, department, county administration or contracted employer that participates in SHBP.

Enrolled Member
A person who meets all eligibility requirements for the Plan as a result of his or her current or former employment, who is currently enrolled in coverage and who has paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

Enrollment Date
The first day you are covered under the Plan or, if the Plan imposes a waiting period, the first day of your waiting period.

Excluded Services (Benefit Exclusion)
Health care services your Plan does not cover.

Experimental / Investigational
Services which are considered Experimental / 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:

1. 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;
2. 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 Medikcus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
3. Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t)(2) of the Social Security Act;
4. 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;
5. 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

6. 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 Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health Facility, as defined in this SPD. The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by the Medical Claims Administrator.

Health Plan or Plan
See definition “State Health Benefit Plan”

Home Health Care Agency
A Facility, licensed in the state in which it is located, that:

- Gives skilled nursing and other services on a visiting basis in your home; and
- 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. The provider must be licensed by the appropriate agency.

Hospital
A Provider licensed and operated as required by law which has:

- Room, board and nursing care;
- A staff with one or more Doctors on hand at all times;
- 24-hour nursing service;
- All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
- Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care
- Subacute care
- Treatment of alcohol abuse
- Treatment of drug abuse

Identification Card (ID Card)
The latest Member ID Card given to you will show 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 Medical 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.

Maximum Allowed Amount
The maximum payment that the Medical Claims Administrator will allow for Covered Services. For more information, see the "Claims Payment" Section.

Medical Claims Administrator
Anthem Blue Cross and Blue Shield, is the Medical Claims Administrator and provides administrative claims payment and certain medical management services only.

Medical Necessity (Medically Necessary)
The Medical 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 Medical Claims Administrator considers a service Medically Necessary if it is:

1. Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
2. Compatible with the standards of acceptable medical practice in the United States;
3. Not provided solely for your convenience or the convenience of the Doctor, health care Provider or Hospital;
4. Not primarily Custodial Care;
5. 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
6. 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 or Covered Member
People, including the Covered Person and his/her Dependents, who have met the eligibility requirements, applied for coverage, enrolled in the Plan, and paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

Non-Covered Provider
Providers who are not licensed by law and do not fall into the Provider or Facility Definitions. Examples of Non-Covered Providers include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

Non-Preferred Provider
A Hospital, Freestanding Ambulatory Facility (Surgical Center), Doctor, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have a Point of Service Contract with Contract with the Medical Claims Administrator but is contracted with the Medical Claims Administrator's indemnity network.

Note: Out-of-network Benefits apply when Covered Services are rendered by a Non-Preferred Provider.

Out-of-Network Provider
A Provider that does not have an agreement or contract with the Claims, or the Medical Claims Administrator's subcontractor(s), to give Covered Services to Members under this Plan. You will often get a lower level of Benefits when you use Out-of-Network Providers.

Out-of-Pocket Maximum
The maximum amount, including your yearly Deductible and Co-insurance, you may have to pay each year with your own money for covered health services. If you reach the Out-of-Pocket Maximum, your eligible expenses are covered 100% by the plan for the remainder of the plan year. The Out-of-Pocket Maximum is higher for Out-of-Network services.

The most you pay in Deductibles and Co-insurance during a Benefit Period for Covered Services. The Out-of-Pocket Maximum does not include your premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan does not cover. The Out-of-Pocket Maximum consists of Deductibles and Co-insurance. See "Schedule of Benefits" for details.

Physician (Medical 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.

Plan
The State Health Benefit Plan

Plan Administrator
The Georgia Department of Community Health, SHBP Division. References to "we", "us", and "our" in this SPD are to the Department of Community Health, SHBP Division.

Note: The Plan Administrator is not the Medical Claims Administrator.

Plan Year
January 1 to December 31

Plan Sponsor
The Georgia Department of Community Health
Note: The Plan Sponsor is not the Medical Claims Administrator.

Precertification
See Section "Getting Approval for Benefits" for details.

Predetermination
See Section "Getting Approval for Benefits" for details.

Prescription Drug
A medicine made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, containing two or more ingredients, all of which must be covered ingredients by the plan, and at least one ingredient must require a prescription. Compounded medications cannot essentially be a copy of commercially available drug products
- Insulin, diabetic supplies, and syringes.

Note: Prescription Drugs you get from a Retail or Mail Order Pharmacy are not covered by Anthem. The Prescription Drug Benefits retail, mail order and specialty drug programs are administered by CVS

Caremark. Refer to the Outpatient Prescription Drug Rider in this SPD.

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, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

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

Prior Authorization
See "Getting Approval for Benefits" Sections for details.

Provider
A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by the Medical Claims Administrator. If you have a question about a Provider not described in this SPD please call the number on your Anthem Member ID Card.
Professional Providers include:

- 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;
- Doctor of Dental Medicine (D.D.M.) and Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services, and
- Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Recovery
See "Subrogation and Reimbursement" Section for details.

Referral
See "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 commonly staffed by Physician Assistants and nurse practitioners.

Service Area
The geographical area where you can receive Covered Services.

Skilled Nursing Facility
A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by the Medical Claims Administrator. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; 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, due to a qualifying event such as marriage, birth, adoption, etc. See the separate SPD "Eligibility and Enrollment Provisions Booklet" 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.

State Health Benefit Plan (SHBP)
The State Health Benefit Plan is comprised of three self-insured plans established by Georgia law: 1) for State employees (O.C.G.A. § 45-18-2), 2) for teachers (O.C.G.A. § 20-2-881), and 3) for non-certified public school employees (O.C.G.A. § 20-2-911). Covered Services are the same under all three self-insured plans and they are usually referred to together as the State Health Benefit Plan.

Summary Plan Description (SPD)
The SPD provides you with a summary description of your SHBP Benefits for Covered Services while you are enrolled under the Plan. The SPD contain a summary description of your Benefits while you are enrolled in the Plan.

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

End of Medical Claims Administrator Section

WELLNESS PROGRAM ADMINISTRATOR

sharecare

Well-Being Program- *Be Well SHBP*

Well-Being Program Description – *Be Well SHBP*
State Health Benefit Plan (SHBP) will continue to sponsor Well-Being Programs through the Wellness Program Administrator, Sharecare. Sharecare will provide you with support, new tools and redesigned lifestyle management information you need to improve your own health and well-being. The Sharecare app is a mobile first option that you will find enhances your ability to engage in the program.

Well-Being Incentive Points
Feel better by earning up to 480 well-being incentive points. Sign up for an account at www.BeWellSHBP.com and then complete the RealAge Test and participate in other healthy actions to earn the well-being incentive points. Well-being incentive points will not be awarded until after the completion of the RealAge Test. For details or questions go to www.BeWellSHBP.com or call 888-616-6411.

NOTE: All actions must be completed and appropriate documentation submitted by November 30, 2021, including the biometric screening. This can be done at an SHBP-sponsored screening event, by your healthcare provider submitting the 2021 Physician Screening Form, or at a Quest Diagnostic Patient Service Center (PSC). Sharecare must receive this documentation between January 1, 2021 and November 30, 2021. It is your responsibility to ensure your information is complete and all documentation (including the 2021 Physician Screening Form) is received by Sharecare by November 30, 2021. After your physician has completed and signed your 2021 Physician Screening Form, you are allowed to fax the form to Sharecare.

In 2021, you and your covered spouse are each eligible to earn a well-being reward of up to 480 well-being incentive points when you are enrolled in Anthem Blue Cross and Blue Shield (Anthem) and complete the well-being activities below between January 1, 2021 and November 30, 2021. That is a total of 960 well-being incentive points.

You and your covered spouse can each earn 480 well-being incentive points and choose to redeem them for either: 1) a $150 Visa Reward Card to use anywhere Visa is accepted (when redeeming all 480 well-being incentive points earned in 2021) OR 2) 480 well-being incentive credits (to apply toward eligible medical and pharmacy expenses). The well-being incentive points you earn in 2021 can be redeemed for well-being incentive credits in increments of 120.

What to Do	*What You will Earn*
Assess Your Health - Complete the RealAge Test A confidential, online questionnaire that will take about 10 minutes to complete. It is recommended that you complete the RealAge Test early in 2021.	***Earn 120 well-being incentive points***
Know Your Numbers – Complete a Biometric Screening (Points to be awarded after the RealAge Test is completed) You have three options: through your physician using the 2021 Physician Screening Form, at an SHBP-sponsored biometric screening event, or at a Quest Diagnostic Patient Service Center (PSC).	***Earn 120 well-being incentive points***

What to Do	*What You will Earn*
Take Action (Points to be earned after the RealAge Test is completed) Complete the Coaching Pathway, Online Pathway, RealAge Program, or a Combination of all Three. **Telephonic Coaching Pathway** Actively engage in telephonic coaching. Earn 60 well-being incentive points for one completed coaching call per calendar month. You can earn 60 well-being incentive points up to 4 times, for a maximum of 240 well-being incentive points **Online Pathway or Challenges** Earn 120 well-being incentive points up to 2 times, for a maximum of 240 well-being incentive points by completing two of the following challenges within the challenge period as listed below: • *5,000 Steps Challenge (complete and track 21 of 30 days in January, April, July, or October)* • *Stress Challenge (complete and track 21 of 30 days in February, May, August, or November)* • *Green Day Challenge (complete and track 21 of 30 days in March, June, or September)* ***NOTE:*** Well-being incentive points can be earned by logging 8 Green Day trackers daily within the Sharecare App or online through www.BeWellSHBP.com. **RealAge Program** Earn 120 well-being incentive points one time for completing the RealAge Program. You may start the challenge at any time during the program year, but once started you must track at least 4 times a week (Sunday- Saturday) over 3 consecutive weeks to be awarded well-being incentive points.	***Earn up to 240 well-being incentive points*** ***NOTE:*** *You may complete as many coaching calls as you like in a month; however, a maximum of one call in a calendar month qualifies you for the 60 well-being incentive points.* ***NOTE:*** *Well-being incentive points cannot be awarded until completion of the RealAge Test. Biometrics, Telephonic Coaching, RealAge Program and Online Pathways completed before completion of the RealAge Test can only be applied to well-being incentive points upon RealAge Test completion.*
Note: If you terminate your coverage with SHBP, any unused HRA credits will be forfeited.	

Well-being incentive points are saved in the Sharecare Redemption Center until you choose to redeem them, meaning well-being incentive points will not be sent automatically to Anthem. Therefore, you and your covered spouse must make your selection on how you choose to redeem your points through the Redemption Center, by visiting www.BeWellSHBP.com.

If you elect to redeem all 480 well-being incentive points earned in 2021 for the $150 Visa Reward Card it will be physically mailed within 4 to 8 weeks of redemption. If you elect to redeem your points for well-being incentive credits to apply toward eligible medical and pharmacy expenses, you may do so in increments of 120 (up to a maximum of 480). Well-being incentive credits will be available within 30 days of redemption and will be deposited into your HRA account. Note: Once you redeem any of the 2021 well-being incentive points for well-being credits you will no longer be able to select the Visa Reward Card option. You must redeem your points for only one of the available two options.

Getting Started

To get started log onto www.BeWellSHBP.com and follow the instructions to register and take your RealAge Test. You will be asked to enter six registration credentials of First Name, Last Name, Date of Birth, Gender,

Zip Code and the last four digits of your Social Security Number (SSN).

Note: To access the Sharecare App that is specific to SHBP members, **you must** go to www.BeWellSHBP.com and sign up first. You can then download the Sharecare app, but you will need to use the same log in information used on the website to ensure your account is linked correctly.

Well-being Incentive Credit Rollover Between Plan Options and Medical Claims Administrators

All unused well-being incentive credits redeemed while participating in the SHBP Well-Being Program called *Be Well SHBP* will roll over whether you remained enrolled in your current Plan Option and medical claims administrator or changed to another Plan Option and/or medical claims administrator.

This means no matter which Plan Option you select (excluding TRICARE Supplement), you will not forfeit any unused well-being incentive credits that have been redeemed.

Note: Unused well-being incentive credits will rollover in April of 2021. This allows unused well-being incentive credits to be used to pay your out-of-pocket expenses for 2020 claims filed after December 31, 2020. There is a date limitation to when you may use the 2020 rollover credits for reimbursement. Only eligible medical expenses incurred after the rollover in April 2021 will qualify for reimbursement using the 2020 well-being incentive credit rollover funds. Expenses for services incurred from January to March 2021 are not eligible for reimbursement from 2020 rollover credits. However, until your 2020 credits roll over, your 2021 HRA credits funded by SHBP and any 2021 well-being incentive credits earned and available at the time claims are received by Anthem may be used for those expenses during this time period.

Sharecare Well-Being Services

You can access the SHBP *Be Well* program at, www.BeWellSHBP.com. The key components of the program are listed below.

- RealAge Test: A clinically validated health risk assessment.
- Daily Trackers (Green Days): Engagement data to track key RealAge Test health indicators.
- Digital Health Programs: Personalized recommendations, suggested content, targeted insights, and customized messages.
- Content Library: Articles, questions and answers, videos, health topics, and much more.
- AskMD: Evidence-based and customizable symptom checker tool.
- Personal Health Profile: Personal health record where members can access their health history in one place.
- Mobile Application and Smart Phone Technology: The Sharecare App places the power of the Sharecare App in the hands of smart phone users.
- Online Campaigns and Challenges: The Groups and Challenges feature allows Members to interact with one another or compete against one another in pre-defined challenges for walking (steps program), exercise, stress management and healthy living.
- RealAge Program: Upon completion of the RealAge® Test you can begin participating in the RealAge® Program, a comprehensive healthy behavior program targeting the 4 highest lifestyle risks – Stress, Sleep, Nutrition and Activity.
- Device integration to promote fitness, exercise and health and Well-Being: Members using the Sharecare App can link their own devices to the trackers. Once linked, the device will share its data with the application automatically updating the Green Day Trackers. Members may also rely on their personal cell phone to establish some trackers, not relying on an external devise. Members are responsible for making sure that the information is properly tracked.
- Well-Being Incentive Points and Rewards Tracking: Your incentive status will be listed under the Rewards section of the Sharecare App or online. Please be sure to first register on www.BeWellSHBP.com and complete your RealAge Test through the Sharecare App or online.

Sharecare RealAge Test

The RealAge Test is Sharecare's clinically-validated health risk assessment that guides you through a series of questions designed to gauge how fast you are aging based on your lifestyle, genetics, and medical history as well as often overlooked risk factors like relationships and stress. RealAge is your first step to get started with Sharecare, as it helps you understand which of your lifestyle habits are impacting your health. From there, Sharecare provides you with content and programs to help you improve your overall health and obtain a younger RealAge. It takes about 10 minutes to complete the RealAge Test. The answers you provide will not be shared with your employer or SHBP.

Biometric Screenings

A Biometric Screening provides an excellent opportunity to know your biometric numbers and what they mean for you. The screening typically takes 10-15 minutes. During a biometric screening event, a health professional will collect measurements, including body mass index (BMI), blood pressure, cholesterol, glucose, and hemoglobin A1c (HbA1c). In 2021, SHBP Members and covered spouses will have the opportunity to obtain a biometric screening at their personal Physician's office, at an SHBP-sponsored biometric screening event, or at a Quest Patient Service Center (PSC). For information on biometric screenings please visit www.BeWellSHBP.com or call Sharecare at 888-616-6411.

2021 Physician Screening Form

You may complete your screening with your Physician and utilize an easy-to-use 2021 Physician Screening Form. The form can be accessed through www.BeWellSHBP.com, printed from your computer and taken to your Physician for completion. Each individual will need to log in and enter their first and last name as it appears on their Anthem Member ID card, date of birth, zip code and gender to pre-populate the form. Any

2021 Physician Screening Forms not pre-populated will not be processed. The 2021 Physician Screening Form processing oversight is handled by Sharecare.

If the 2021 Physician Screening Form submitted by your Physician is incomplete (i.e., missing pre- populated Member information, missing Physician signature or participant signature), your form will not be processed. In order to process your form and have your results loaded, you will need to work with your Physician's office to ensure that the form is signed and submitted by the deadline of November 30, 2021. If your form is signed, but only partially completed, your form will be processed as is and will only show results for the data provided. Well-being incentive points will only be awarded when all of the results are complete. For information on Physician Screening Forms, please visit www.BeWellSHBP.com or call 888-616-6411.

It is your responsibility to ensure your information is complete and all documentation (including the 2021 Physician Screening Form) is received by Sharecare by November 30, 2021. After your physician has completed and signed your Physician Screening Form, you are allowed to fax the form to Sharecare if necessary.

Telephonic Well-Being Coaching

Telephonic coaching is designed to help you address identified risks factors and to create a plan to reduce risks and improve your overall health. Areas of risk that coaching can support include: exercise, healthy eating, stress management, tobacco cessation and weight management, as well as other risk areas.

Well-Being Coaches maintain confidentiality and work to establish attainable goals collaboratively with you. Your coach will have confidential access to your Well-Being Plan, including your RealAge Test and biometric data, and will be able to see your progress towards your goals. Well-Being Coaching support is provided as long as you need it. Additionally, you can make unlimited in-bound calls for ongoing support as needed.

Individuals identified for coaching will be directly contacted to enroll in the Well-Being Coaching program. Individuals not identified for coaching support may self-enroll by calling 888-616-6411. If you wish to unenroll from coaching calls, please call 888-616-6411.

Online Pathway or Challenges

Within the Sharecare app or online platform, join and complete monthly challenges:

- Complete 5,000 Steps per day within the challenge period; or
- Update your Stress per day within the challenge period; or
- Log your 8 Green Day trackers per day within the period, which include daily trackers such as steps, sleep, stress, blood pressure, weight, and smoking.

RealAge Program

Upon completion of the RealAge® Test (within the Sharecare app or the online platform) you can begin participating in the RealAge® Program, a comprehensive healthy behavior program targeting the 4 highest lifestyle risks – Stress, Sleep, Nutrition and Activity.

Family Centered Well-Being

The *Be Well SHBP* program is focused on Family centered well-being. Log onto www.BeWellSHBP.com to learn more about the resources available to support members and their families.

Live Chat

Enables Members to directly outreach to member services staff.

Onsite Well-being Support

Presentations and webinars given at your worksite on a variety of topics including healthy eating, family well-being, increasing physical activity, stress management, preventive care and more. Worksite

Well-Being ambassadors program to keep you informed and motivated.

Well-Being Incentive Tracking

Through Sharecare's Redemption Center, the Rewards section of the Sharecare App or online, you can see up to date statuses regarding well-being incentive points. This includes completion of the RealAge Test and biometric screening, enrollment and engagement in Well-Being Coaching, and online challenges and programs. Please be sure to first register on www.BeWellSHBP.com and complete your RealAge Test through the Sharecare App or online. You can perform a screen print function to show evidence that you completed the required activities for program completion.

Timelines for Actions to be Posted

The RealAge Test will be live on January 1, 2021. Immediately after taking the RealAge Test you can begin participating in the online challenges, a RealAge Program, and you will receive personalized messaging and much more meant just for you. You have until November 30, 2021 to complete the activities to earn well-being incentive points for 2021.

You and your covered spouse can each earn 480 well-being incentive points and choose to redeem them for either: 1) a $150 Visa Reward Card to use anywhere Visa is accepted (when redeeming all 480 well-being incentive points earned in 2021) OR 2) 480 well-being incentive credits (to apply toward eligible medical and pharmacy expenses). The well-being incentive points you earn in 2021 can be redeemed for well-being incentive credits in increments of 120.

The 2021 action-based incentive points will be earned as the action is completed and will be available in your incentive account within 30 days after redemption.

Well-being incentive points are saved in the Sharecare Redemption Center until you choose to redeem them. All points must be redeemed by midnight Eastern Time on December 15, 2021. Well-being incentive points not redeemed by **December 15, 2021** will be sent to your respective SHBP Medical Claims Administrator as well-being incentive credits to be used towards eligible medical and pharmacy expenses.

You will not be able to select the Visa Reward Card option if you begin redeeming well-being incentive points to apply towards your well-being incentive credits.

You must complete all well-being activities totaling 480 well-being incentive points in order to select the $150 Visa Reward Card option. The card will be physically mailed within 4 to 8 weeks of redemption.

Actions must be completed between January 1, 2021 and November 30, 2021 to earn the 2021 well-being incentive points.

If your well-being incentive points are not properly displaying in the Rewards section of the Sharecare App or in the Sharecare Redemption Center, please call Sharecare at 888-616-6411.

Tobacco Surcharge Policies and Cessation

Tobacco Surcharge

Tobacco surcharges are included in all SHBP Options (other than Medicare Advantage Options and TRICARE). These surcharges are intended to promote tobacco cessation and the use of the Tobacco Cessation Telephonic Coaching or Online Tobacco Cessation Programs.

Go to www.shbp.georgia.gov to access the tobacco surcharge removal policies and forms. These policies allow you to have the tobacco surcharge removed by completing the tobacco surcharge removal requirements through Sharecare. **The Tobacco Surcharge Removal Policy applies to tobacco and electronic nicotine delivery systems (also known as vapes or e-cigarettes).**

If you and your enrolled Dependents complete the Tobacco Surcharge removal requirements, you will be able to avoid the surcharge for the entire year. This means that any surcharge paid in 2021 may be refunded after the completion of the tobacco surcharge removal requirements. The tobacco surcharge removal requirements must all be completed in 2021. Contact Sharecare at 888-616-6411 for more information.

If you think you may be unable to complete the tobacco surcharge removal requirements, you may qualify for an opportunity to avoid the tobacco surcharge by different means. Contact Sharecare at 888-616-6411 and Sharecare will work with you (and, if you wish, with your doctor) to find a well-being program with the same reward that is right for you in light of your health status.

Telephonic Well-Being Coaching and Online Program for Tobacco Cessation

Resources for quitting tobacco that are available to eligible Members, covered spouses and dependents 18 years and older:

- Phone coaching sessions with a trained counselor
- Access to Nicotine Replacement Therapy coverage – see Pharmacy Benefits Administrator section
- Self-refer into coaching or online support via www.BeWellSHBP.com

Individuals identified for tobacco coaching will be directly contacted to enroll in the coaching program. Individuals not identified for coaching support may self-enroll by calling 888-616-6411.

2021 Well-Being Incentive Points Appeal Process

If you or your covered Spouse, or both, are advised that your 2021 Well-Being Incentive Points were not obtained, you may appeal this decision directly to Sharecare. Appeals, along with the requested documents, must be submitted by 5:00 pm, ET **January 31, 2022.** Well-Being Incentive Points Appeals submitted after this date will be denied.

All appeals approved on or after December 1, 2021 will apply towards redemption of well-being incentive credits. The Visa Reward Card will not be an option.

Level I – Well-Being Incentive Points Appeals
To file a Well-Being Incentive Points Appeal, complete all applicable sections on the Level 1 - 2021 Well-Being Incentive Points Appeal Form located at www.BeWellSHBP.com, sign and date the form. If the 2021 Well-Being Activity in question was not satisfied due to circumstances beyond your control, you should explain why in the space provided on the Level 1 - 2021 Well-Being Incentive Points Appeal Form. Examples of "circumstances beyond your control" include, but are not limited to, the following: long term hospital stay, and hospice stay.

You should submit the form, along with the supporting documentation, to the email, fax or mailing address located on the Level 1 - 2021 Well-Being Incentive Points Appeal Form. An example of appropriate supporting documentation includes:

- A copy of the completed 2021 Physician Screening Form and confirmation that it was sent to Sharecare by the November 30, 2021 deadline (if applicable).
- A copy of the Know Your Numbers Form as proof on onsite screening participation upon completion at a SHBP-sponsored screening event.
- Print screen or take a snapshot of the incentive status when activities through the Sharecare App or online are complete.

Level II – Formal Appeal
If your 2021 Well-Being Incentive Points Appeal is denied, you may file a Formal Appeal, which must be postmarked within fifteen (15) calendar days following the date of the 2021 Level 1 Well-Being Incentive Points Appeal decision. To file a Formal Appeal, you must complete the Level 2 – 2021 Well-Being Incentive Points Appeal Form and attach a copy of the 2021 Level 1 Appeal decision, along with any supporting documentation. The Level 2 – 2021 Well-Being Incentive Points Appeal form is located at www.BeWellSHBP.com. Instructions are included on the form.

Generally, a decision by the Formal Appeal committee will be issued within thirty (30) calendar days following receipt. The written notice of the decision by the Committee is the final step in the administrative proceedings and will exhaust all administrative remedies.

Please forward all written requests for Formal Appeals along with a completed Level 2 2021 Well-Being Incentive Points Appeal Form to the email, fax or mailing address located on the Appeal Form. The appeal form is available at www.BeWellSHBP.com.

Sharecare Definitions

RealAge Test
The RealAge Test is Sharecare's clinically-validated health risk assessment that guides you through a series of questions designed to gauge how fast you are aging based on your lifestyle, genetics, and medical history as well as often overlooked risk factors like relationships and stress. The RealAge Test is your first step to get started with Sharecare, as it helps you understand which of your good and bad habits are impacting your health. From there, Sharecare provides you with content and programs to help you improve your overall health and obtain a younger RealAge. It takes about 10 minutes to complete the RealAge Test. The answers you provide will not be shared with your employer or SHBP.

Member or Covered Member
People, including the Covered Person and his/her Dependents, who have met the eligibility requirements, applied for coverage, enrolled in the Plan, and paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

Physician Screening Form
The Physician Screening Form is a form that your physician can complete with biometric results from your wellness visit or annual physical exam.

Well-Being Coaching
Well-Being Coaching helps you find opportunities to improve well-being every day. Through convenient phone-based sessions, Well-Being Coaching guides you through healthy behavior changes by building on your strengths. The program is confidential, voluntary, and offered to you as part of your plan benefits at no additional cost to you. You decide if you want to participate and how involved you want to be. All calls are scheduled at your convenience and on your timeline. With help from Well-Being Coaching you can:

- Better understand your health risks.
- Get answers to your health questions.
- Find support to gain more control over your health.
- Set goals to reach your healthy best.

Sharecare App
The Sharecare App is a health and wellness engagement mobile tool that provides personalized information, programs and resources to improve your health. It provides personalized information to you based on your response to the RealAge Test.

Health Profile
Provides an overview of all your health data in one place based on the results of your RealAge Test, trackers, AskMD, and with your permission, can include data ingested from your biometrics and claims.

Green Day Tracker
Sharecare Green Day Tracker (GDT) includes daily trackers, which are core to the RealAge calculation. The trackers include, steps, sleep, stress, relationships, blood pressure, weight, smoking exposure, cholesterol, alcohol, fitness and health, diet, medication adherence, and blood glucose. In order to accomplish a Green Day, you will need to enter data for 8 trackers within the green range daily to improve your RealAge.

End of the Wellness Program Administrator Section

PHARMACY BENEFITS ADMINISTRATOR

OUTPATIENT PRESCRIPTION DRUG RIDER

This Rider to the Summary Plan Description (SPD) provides Benefits for outpatient Prescription Drug Products. CVS Caremark administers your Prescription Drug Pharmacy Benefits. Because this Rider is part of a legal document, we want to give you information about this document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the CVS Caremark Pharmacy Definition Section. When we use the words “we,” “us” and “our” in this document, we are referring to Department of Community Health (DCH), State Health Benefit Plan (SHBP) Division. When we use the words “you” and “your,” we are referring to people who are Covered Members.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy, CVS Caremark Mail Order, CVS Specialty or an out-of-network pharmacy.

Prescription Drug Product Benefits will be coordinated with those of any other health coverage plan as described in Section “What’s Covered- Prescription Drug Benefits”.

CVS Caremark administers the pharmacy benefits for Members and their Covered Dependent(s) enrolled in Anthem Blue Cross and Blue Shield Non-Medicare Advantage Plan Options for 2021.

Note: Members do not have to go to a CVS pharmacy location for their prescriptions. CVS Caremark has a broad pharmacy network. Members and their Covered Dependent(s) can continue to use local retail and/or chain pharmacies to obtain their prescription medications. Please visit the CVS Caremark’s pharmacy locator tool to find a network pharmacy near you.

Benefits for Outpatient Prescription Drug Products

This Rider will cover a detailed description about your prescription drug plan benefit supply limits; prior authorizations (PA); maintenance medications; covered medications; non-covered medications; definitions of Generic and Brand-name medications; and the step therapy (ST) program.

Benefits are available for outpatient Prescription Drug Products on the CVS Caremark preferred drug list (PDL), which meet the definition of a covered health service and are dispensed at a licensed pharmacy. Co-insurance (or other payments you are responsible for will vary depending on the outpatient Prescription Drug Product’s placement within the three (3) tiers of the CVS Caremark PDL. See the Prescription Drug Pharmacy Benefits Co-insurance table in the “Schedule of Benefits” Section.

Payment Information

Co-insurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the allowed amount. Your Co-insurance is based on which tier the drug falls into and is determined by CVS Caremark, the Pharmacy Benefits Administrator. Co-insurance amounts will not be overridden or changed on an individual basis.

Note: Co-insurance amounts do not go toward the deductible; however, they do go toward the Out-of-Pocket Maximum.

Gold, Silver, & Bronze HRA Plans	
Prescription Drug Pharmacy Benefits Co-insurance you must pay	
31-day supply for a participating Retail Network Pharmacy	
Tier 1 Co-insurance (Generic drugs and some select preferred Brand-name drugs)	15% ($20 min/ $50 max) for up to 31-day supply
Tier 2 Co-insurance (Preferred drugs)	25% ($50 min/ $80 max) for up to 31-day supply
Tier 3 Co-insurance (Non-Preferred drugs)	25% ($80 min/ $125 max) for up to 31-day supply
90-day Supply for maintenance drugs from mail order OR at participating 90-Day Retail Network Pharmacies	
Tier 1: 2½ x the monthly Co-insurance	15% ($50 min/ $125 max) for up to a 90-day supply
Tier 2: 2½ x the monthly Co-insurance	25% ($125 min/ $200 max) for up to a 90-day supply
Tier 3: 2½ x the monthly Co-insurance	25% ($200 min/ $312.50 max) for up to a 90-day supply
90-day Supply for maintenance drugs from a Retail Network Pharmacy which is not part of the 90-Day Retail Network Pharmacies	
Tier 1: 3 x the monthly Co-insurance	15% ($60 min/ $150 max) for up to a 90-day supply
Tier 2: 3 x the monthly Co-insurance	25% ($150 min/ $240 max) for up to a 90-day supply
Tier 3: 3 x the monthly Co-insurance	25% ($240 min/ $375 max) for up to a 90-day supply

Prescription drug pharmacy benefits are administered separately by the Pharmacy Benefits Claims Administrator, CVS Caremark and are the same in all three Plan options- Gold, Silver, and Bronze HRA Plans.

Co-insurance for a Prescription Drug Product at Network Pharmacy is a percentage of the allowed amount. Your Co-insurance is based on the applicable drug tier. Co-insurance will not be overridden or changed on an individual basis.

If a Generic product is available and you or your physician choose to use the Branded product instead, then you will pay the applicable Brand Co-insurance plus the cost difference between the Generic product and its Brand product, referred to as Ancillary Charge. This differential will not apply to your Out-of-Pocket Maximum.

Note: Prescription costs do not apply to the Deductible but do apply to the Member's Out-of-Pocket Maximum.

Note: Preferred insulin will pay at a Tier 1 Co-insurance and Non-preferred insulin will pay at a Tier 2 Co-insurance.

For Prescription Drug Products at a participating Retail Network Pharmacy, you are responsible for paying:

- The applicable Co-insurance, or
- The applicable Co-insurance and Ancillary CVS Caremark Charge, or
- The Network Pharmacy Usual and Customary Charge, which includes a dispensing fee and may include sales tax for the Prescription Drug Product if this results in a lower price than the applicable Co-insurance.

For Prescription Drug Products from the CVS Caremark Mail Order Pharmacy or CVS Specialty you are responsible for paying:

- The applicable Co-insurance, or
- The applicable Co-insurance and Ancillary Charge, or
- The Prescription Drug Cost for that Prescription Drug Product if this results in a lower price than the applicable Co-insurance.

Coverage Policies and Guidelines

Your CVS Caremark pharmacy benefit provides coverage for a comprehensive selection of Prescription medications. The most commonly prescribed medications for certain conditions are named or described in the 2021 Preferred Drug List (PDL).

Your HRA Plan will have Prescription Medications Placed in Tiers

Prescription medications are categorized within three (3) tiers which are determined by the Pharmacy Benefits Administrator. Each tier is assigned a Co-insurance amount which is determined by the Plan. Please consult the CVS Caremark Preferred Drug List at info.caremark.com/shbp, or call the CVS Caremark Customer Care number on your Anthem Member ID Card for the most up-to-date tier status of your medication(s) and any associated coverage rules (including supply limits, PA requirements, etc.). When you fill a prescription, you pay the Co-insurance at the time the prescription is filled.

The Preferred drug list is developed by CVS Caremark. This list is developed by an independent panel of doctors and pharmacists who ensure the medications are clinically appropriate and cost-effective. Selection criteria sources include but are not limited to: peer-reviewed literature; recognized compendia; consensus documents; nationally sanctioned guidelines and other publications of the National Institutes of Health, Agency for Healthcare Research and Quality, and other organizations or government agencies; drug labeling approved by the FDA; and input from medical specialty practitioners.

Whether a particular Prescription Drug Product is appropriate for an individual Covered Member is a determination that is made between the Member and their prescribing physician.

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. If such a change happens, you may have a change in your required Co-insurance. Tier status and Co-insurance will not be overridden or changed for an individual member.

Member Identification Card (Member ID card) – Network Pharmacy

In order to utilize your Prescription Drug Benefit at a participating retail Network Pharmacy, you should show your Anthem Member ID Card at the time you obtain your prescription drug medication at a participating Retail Network Pharmacy.

If you do not show your Member ID Card at a Network Pharmacy, you will be required to pay the Full Retail Cost.

CVS Specialty

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 the drugs are administered by a healthcare professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. Drugs which have been identified as Specialty Prescription Drugs for your benefit plan are listed on the CVS Caremark website info.caremark.com/shbp. Your prescriptions do not have to be filled through CVS Specialty home delivery program if you have a prescription for one of these

products. See “Glossary and Definitions” for definitions of Specialty Prescription Drug Product and Designated Pharmacy. See “What’s Covered-Prescription Drug Benefits” Section for more information on Specialty Prescription Drug Product.

Care Management Program – Complex Conditions

CVS Health will provide a differentiated care management program that focuses on proactive holistic patient care, including comorbidity management for members with complex conditions requiring specialty pharmacy care. Once enrolled, a dedicated and highly trained care management nurse can proactively provide support to better manage a member’s whole condition through evidence-based interventions, comprehensive patient education, medication, and symptom management – while being available 24/7.

Limitation on Selection of Pharmacies

If CVS Caremark determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies and/or providers may be limited. If this happens, CVS Caremark selects your most recently used Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy and/or provider.

Member Rights and Responsibilities

As a member, you have the right to express concerns about your SHBP coverage and to expect an unbiased resolution of your individual issues. You have the right to submit a written appeal or inquiry regarding any concern that you may have about the prescription drug program or your drug coverage.

CVS Caremark Customer Care

Written appeals and inquiries related to the prescription drug program should be directed to:

Prescription Claim Appeals MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072

Prescription Drug Disclaimer

This SPD summarizes the State Health Benefit Plan Prescription Drug Program. It is not intended to cover all details related to your prescription drug coverage under the SHBP. This SPD is not a contract and the Benefits that are described can be terminated or amended by the Plan Administrator according to applicable laws, rules and regulations. If there are discrepancies between the information in this booklet and DCH Board regulations or the laws of the state of Georgia, or the Board resolutions setting required contributions, those regulations, laws and resolutions will govern at all times.

WHAT IS COVERED - PRESCRIPTION DRUG BENEFITS

CVS Caremark will provide Pharmacy Benefits under the plan for outpatient Prescription Drug Products:

- Designated as covered at the time the prescription is dispensed when obtained from a Network Pharmacy (Retail, Mail Order or Specialty Designated Pharmacy), or when a paper claim is filed and the prescription was designated as covered at the time it was dispensed.
- Refer to exclusions in this Section "What is Not Covered: Prescription Drug Exclusions".

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service.

Benefits for outpatient Prescription Drug Products are available through three types of Network pharmacies: Retail Network Pharmacies; the CVS Caremark Mail Order; and CVS Specialty. You can obtain information about participating Retail Network Pharmacies by calling the toll-free number on your Anthem Member ID card, or on the web at info.caremark.com/shbp.

Covered Members that enroll in Disease Management for Diabetes, Coronary Artery Disease (CAD), Asthma, or Agents for Chemical Dependency may qualify for the Disease Management (DM) Pharmacy Co-insurance Waiver Program, which allows you to get select medications for these disease states at zero Co-insurance. If you have one of these conditions and are interested in participating in the Personal Health Coach Program and learning more about how to qualify for the Co-insurance waiver incentive, please call Anthem Member Services toll-free at 855-641-4862.

When a Brand-name Drug Becomes Available as a Generic

When a Brand-name drug becomes available as a Generic Prescription Drug Product, the cost of the Brand-name Prescription Drug Product may change, and therefore your Co-insurance may change. You will pay the applicable Co-insurance for the Prescription Drug Product. If you or your physician request a Brand-name Prescription Drug Product in place of the chemically equivalent Generic Prescription Drug Product (Generic equivalent), you will pay the applicable Brand Co-insurance amount as well as the difference in cost between the Brand and Generic Drug Product (Ancillary Charge). This Ancillary Charge will not count towards your Out-of-Pocket Maximum.

When You will be Required to Change from a Generic to a Brand-name Medication

Making sure you have access to affordable medications is our priority. To keep costs low, your plan covers a specific list of medications that may change occasionally that will require you to change from a Generic to a Brand-name medication. If this happens, you will be notified of the change by mail. The good news is you will not need a new prescription and the Brand-name medication will be at the same tier Co-insurance as the Generic.

If you continue to fill prescriptions for the Generic medications that will no longer be covered by your plan, you will have to pay the entire cost. To avoid this, change to the Brand-name medication by asking your pharmacist to fill your prescription with the Brand-name medication. If you have questions about your prescription drug coverage, call Customer Care at 1-844-345-3241.

Supply Limits

With the required Co-insurance, you may receive a Prescription Drug Product up to the stated supply limit. You may determine if a Prescription drug has been assigned a supply limit by calling the CVS Caremark Customer Care number on your Anthem Member ID Card or on the web at info.caremark.com/shbp.

Note: Some products are subject to additional supply limits based on criteria that CVS Caremark has developed, subject to its periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum

amount be dispensed.

Network Pharmacy Prior Authorization or Coverage Review Requirements
When Prescription Drug Products are dispensed at a Network Pharmacy and require Prior Authorization (PA), the prescribing Provider or Pharmacist are responsible for requesting approval from CVS Caremark. If a PA has not been approved or submitted for approval before the Prescription Drug Product is dispensed at a participating Network Pharmacy, then the prescription is not eligible for coverage and you will be required to pay the Full Retail Cost (Usual and Customary Charge) for that prescription at the pharmacy. If a PA is requested within twelve (12) months after the date the prescription was filled and the PA is retroactively approved, then you may request reimbursement from CVS Caremark. The Prescription Drug Products requiring PA are subject to periodic review and modification. You may find out whether a particular Prescription Drug Product requires PA by consulting your PDL through info.caremark.com/shbp or by calling the CVS Caremark Customer Care number on your Anthem Member ID Card.

Note: Prior Authorization approval will be required before the claim will be considered for reimbursement. If CVS Caremark is notified within twelve (12) months after you pay the Full Retail Cost and the Prior Authorization is denied, you will not be reimbursed.

Requesting reimbursement for a claim you paid Full Retail Cost
If a prescription is filled by an Out-of-Network Pharmacy or without use of your Anthem Member ID Card you can submit that claim for reimbursement up to twelve (12) months after the date the prescription was filled. If the drug required prior authorization approval and that was not obtained prior to filling the prescription then it can be requested at the time the claim is submitted. If the prior authorization is not approved, then you will not be able to be reimbursed for your claim.

When you submit a claim on this basis, you may pay more because you did not notify CVS Caremark before the Prescription Drug Product was dispensed and because the Out-of-Network Pharmacy you used is not bound by the network pricing under our plan. The amount you are reimbursed will be based on the Network Prescription Drug Cost, less the required Co-insurance and Ancillary Charge, if applicable.

If you wish to seek reimbursement, you may obtain a prescription drug claim form from CVS Caremark by calling the CVS Caremark Customer Care number on your Anthem Member ID Card, or log into info.caremark.com/shbp. Along with the prescription drug claim form, you will need a pharmacy receipt for your prescription and if applicable- an explanation of benefits (EOB) from your primary carrier, if you are submitting your pharmacy claim for secondary coverage.

The prescription drug claim form must be filled out in its entirety and mailed to the address on this form. Any missing information may cause a delay in processing.

Step Therapy Program Requirements
Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or pharmaceutical products, for which Benefits are described in your Summary Plan Description (SPD), are subject to Step Therapy Program requirements (also known as Step Therapy or ST). This means that in order to receive Benefits for such Prescription Drug Products or pharmaceutical products, you are required to use a different Prescription Drug Product first.

You may determine whether a particular Prescription Drug Product or pharmaceutical product is subject to Step Therapy requirements through info.caremark.com/shbp or by calling the CVS Caremark Customer Care number on your Anthem Member ID Card.

Clinical Appeal Process
If a Prior Authorization or quantity limitation request is denied by CVS Caremark, you or your physician may initiate the clinical appeals process. CVS Caremark recommends that a physician initiate an appeal for a denied Prior Authorization decision by CVS Caremark so that all necessary clinical information can be

obtained.

The request/appeal must be submitted in writing (via letter) to CVS Caremark for consideration. The appeal must be submitted within 180 calendar days of the date of the denial letter. This is known as the first-level appeal. The written inquiry should be directed to:

Prescription Claim Appeals MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 866-443-1172

CVS Caremark will advise you in writing of its decision. If CVS Caremark upholds the denial, information regarding the second-level appeal process will be provided to you.

Second-level appeals (an appeal of the first-level appeal decision described above) must be initiated by you or your authorized representative and must be received in writing (via letter). CVS Caremark recommends that a Physician initiate an appeal for a denied first-level appeal decision by CVS Caremark so that all necessary clinical information can be obtained. The second-level appeal must be submitted within 60 calendar days of the date of the first-level appeal denial letter.

The second-level appeal request, along with any new and/or additional supporting documentation, shall be forwarded to CVS Caremark to the address above.

If, after exhausting the two levels of appeal available to you under your plan, you are not satisfied with the second-level appeal determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

- clinical reasons; or
- the exclusions for experimental, investigational or unproven services.

The external review program is not available if the adverse benefit determination is based on explicit benefit exclusions or defined benefit limits. Contact CVS Caremark at the toll-free number on your Anthem Member ID Card for more information.

Preventive Care Medications

Patient Protection Affordable Care Act, Preventive Care Medications, and over-the-counter (OTC) medications are covered as described in the “Prescription Drug Glossary and Definition” in this Section of the SPD. For these Preventive Care Medications to be covered, you must obtain a prescription from your Doctor and meet any specified requirements. As part of the Patient Protection and Affordable Care Act, certain Prescription Drug Products are covered as Preventive Care Medications at no cost to the Member.

You may determine whether a drug is a Preventive Care Medication by calling the CVS Caremark Customer Care number on your Anthem Member ID Card or through the website info.caremark.com/shbp. You may not be responsible for paying Co-insurance for these Preventive Care Medications.

Tobacco Cessation Medications

A total of two (2) 84-day treatment cycles of certain OTC or prescription tobacco cessation medications is available through a Retail Network Pharmacy at no cost to the member per year. A prescription is required for coverage. For a list of the covered tobacco cessation medications, go to info.caremark.com/shbp.

The Tobacco Cessation program are available to Covered Members age 18 and older to assist them to become tobacco-free. Please see the Tobacco Cessation section in the Wellness Administrator section of this SPD. To enroll in the Tobacco Cessation program, please call Sharecare at 888-616-6411.

Patient Safety
CVS Caremark monitors for potential safety issues with drug therapy and will communicate alerts to the pharmacist at the point-of-sale and directly to the prescribing physicians when appropriate.

Coordination of Benefits (COB)
If your spouse or a dependent has coverage from another health plan, the prescription drug benefits provided by the SHBP will be coordinated with the other insurance carrier(s). This means you must present both prescription plans to the pharmacy when filling your prescription. If your other coverage pays as primary then you can request a secondary payment under your SHBP plan from CVS Caremark at the time of purchase. To do this, just request the pharmacist to electronically file SHBP secondary (see below).

Coordination of Pharmacy Benefits between your Medicare Part D plan and SHBP

- If you have a Medicare Part D plan, each time you go to the pharmacy, present both your Medicare Part D and SHBP Anthem Member ID cards.
- When you reach the Medicare Part D coverage gap, you should still present both identification cards and you will pay your SHBP Co-insurance

Note: To be eligible for reimbursement when coordinating pharmacy benefits with your primary insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules, such as Prior Authorization and step therapy, receive approval before your claims may be considered for reimbursement.

Coordination of Pharmacy Benefits between your Primary Prescription Drug Plan (PDP) and SHBP
If you have coverage under another health plan, each time you go to the pharmacy, present both your primary insurance carrier and SHBP Anthem Member ID cards.

Note: To be eligible for reimbursement when coordinating pharmacy benefits with your other insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules, such as Prior Authorization and Step Therapy, receive approval before your claims may be considered for reimbursement.

To request a secondary payment from CVS Caremark after the time of purchase, you can send a prescription drug claim form and attach a copy of the EOB from the primary plan and the pharmacy receipt. You can obtain a copy of the prescription drug claim form by calling the CVS Caremark Customer Care number on your Anthem Member ID Card, or through info.caremark.com/shbp.

When the SHBP is the secondary plan, benefits are coordinated to pay only the difference between the amount paid by the primary plan and the allowable amount payable by the SHBP, less any applicable Co-insurance.

Note: The amount paid as secondary payor will not exceed the allowable amount payable by the SHBP as primary payor. Please call the CVS Caremark Customer Care number on your Anthem Member ID Card for more details. If you have coverage under two SHBP contracts (cross-coverage or dual coverage), Prescription Drug Benefits provided by the SHBP will not be coordinated. Co-insurance will be required for each filled prescription. If you have coverage under a Medicare Advantage plan, benefits provided by the SHBP pharmacy benefits will not be coordinated.

PHARMACY TYPE AND SUPPLY LIMITS

Prescription Drugs from a Participating Retail Network Pharmacy

The following supply limits apply for each fill of medication:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits established for a particular drug under the plan.
- You may obtain a three-month supply at one time for drugs identified by CVS Caremark as maintenance medications, if you pay the applicable Co-insurance payment for each month supplied based on the type of pharmacy used (standard retail pharmacy or 90-day network pharmacy).

NOTE: When you fill your maintenance medication for a 90-day supply at a 90-Day network participating pharmacy, you can save money. CVS Caremark offers two ways to obtain up to a 90-day supply of maintenance drugs at a lower cost:

1. Some participating retail pharmacies in our network allow you to get up to a 90-day supply of maintenance drugs at the home delivery Co-insurance rates. These are called 90-day retail network pharmacies. To determine which participating retail pharmacies pass through the discounted Co-insurance rates for a 90-day supply, visit info.caremark.com/shbp and click "Find a Local Pharmacy." Any participating 90-day retail pharmacy will have an icon indicating that the pharmacy has the ability to provide up to a 90-day supply of a maintenance medication at a home delivery rate. You can also locate participating retail pharmacies on the CVS Caremark mobile app or call CVS Caremark at the number on your Anthem Member ID Card.
2. You can use the CVS Caremark Mail Order.

Note: Pharmacy benefits apply only if your prescription is for a Covered Health Service, and not for experimental, investigational or unproven services. Otherwise, you are responsible for paying 100% of the cost.

Your Co-insurance is determined by the Prescription Drug List (PDL). All Prescription Drug Products on the PDL are assigned to Tier 1, Tier 2 or Tier 3. To determine tier status, view the PDL at info.caremark.com/shbp, or call the CVS Caremark Customer Care number on your Member ID Card.

Note: Prescription Co-insurance does not apply to the Deductible but does apply to the Member's Out-of-Pocket Maximum. Co-insurance payments will not be overridden or changed on an individual basis.

Coverage for up to a 31-day supply for a participating Retail Network Pharmacy:

Tier 1: 15% Min $20, Max $50
Tier 2: 25% Min $50, Max $80
Tier 3: 25% Min $80, Max $125

Coverage for up to a 90-day supply at a standard participating Retail Network Pharmacy, not part of the 90-day network:

Tier 1: 3 x the monthly Co-insurance for up to a 90-day supply 15% Min $60, Max $150
Tier 2: 3 x the monthly Co-insurance for up to a 90-day supply 25% Min $150, Max $240
Tier 3: 3 x the monthly Co-insurance for up to a 90-day supply 25% Min $240, Max $375

Coverage for up to a 90-day supply at a 90-Day Retail Network Pharmacy:

Tier 1: 2 ½ x the monthly Co-insurance for up to a 90-day supply 15% Min $50, Max $125
Tier 2: 2 ½ x the monthly Co-insurance for up to a 90-day supply 25% Min $125, Max $200
Tier 3: 2 ½ x the monthly Co-insurance for up to a 90-day supply 25% Min $200, Max $312.50

Coverage for up to 31-day supply from a Retail Non-Network Pharmacy
In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-network pharmacy. If the out-of-network pharmacy you use bills more than the Plan would reimburse for that same drug to a network pharmacy under their contracted rates then you must pay the difference in cost plus your Co-insurance as outlined for a participating retail pharmacy above. The same supply limits exist for out-of-network prescriptions as those described above for in-network prescriptions.

Specialty Prescription Drug Products
For Benefits provided for outpatient Specialty Prescription Drug Products, the following apply:

- As written by a Physician up to a 31-day supply; or
- Up to a 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits established for a particular drug by the plan.
- When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a 31-day supply, the Co-insurance that applies will reflect the number of days dispensed.

Specialty Coverage for up to a 31-day supply:

Tier 1: 15% Min $20, Max $50
Tier 2: 25% Min $50, Max $80
Tier 3: 25% Min $80, Max $125

Prescription Drug Products from CVS Caremark Mail Order
The following supply limits apply for Benefits for outpatient Prescription Drug Products dispensed by the CVS Caremark Mail Order:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits established for a particular drug by the plan.
- Your doctor must write your prescription for a 90-day or 3-month supply with refills when appropriate (not a 1-month supply with three refills).

To fill the prescription, you may:

- Mail your prescription(s) along with the required form to CVS Caremark Mail Order.
- Ask your Doctor to call 844-345-3241 for instructions on how to fax the prescription. Your Doctor must include your Member ID number.
- Order through the CVS Caremark website after you register at info.caremark.com/shbp.
- Drop off your prescription at your local CVS Retail Pharmacy who will have your prescription filled through the mail order coverage.

Coverage up to a consecutive 90-day supply through Mail Order:

Tier 1: 2 ½ x the monthly Co-insurance for up to a 90-day supply 15% Min $50, Max $125
Tier 2: 2 ½ x the monthly Co-insurance for up to a 90-day supply 25% Min $125, Max $200
Tier 3: 2 ½ x the monthly Co-insurance for up to a 90-day supply 25% Min $200, Max $312.50

WHAT IS NOT COVERED – PRESCRIPTION DRUG EXCLUSIONS

Exclusions from coverage listed in the SPD apply also to this Rider. In addition, the following prescription drug exclusions apply:

1. Prescriptions that have been prescribed based solely on electronic patient questionnaires or by any other means where there is no proper relationship between the practitioner and patient.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) that exceeds the supply limit.
3. Drugs that are dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility or Alternate Facility.
4. Experimental, Investigational or Unproven Services and medications; medications and/or indications not approved by the Food and Drug Administration (FDA) used for experimental indications and/or dosage regimens determined by CVS Caremark to be experimental, investigational or unproven.
5. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or Benefits are provided or available from the local, state or Federal government (for example, Medicare) whether or not payment or Benefits are received, except as otherwise provided by law.
6. Prescription Drug Products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which Benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or Benefits are received.
7. Any product dispensed for the purpose of appetite suppression and other weight loss products.
8. Some injectable Prescription Drug Product (including, but not limited to, immunizations and allergy serum) that, due to its characteristics as determined by CVS Caremark, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to flu, Gardasil, and Zostavax vaccines, self-administered injectable medications, select physician administered injectable medications and Specialty medications covered through your Pharmacy Benefit Plan.
9. The cost of labor and additional charges for compounding prescriptions, excluding contractual dispensing fees that Pharmacies charge.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins except the following, which require a prescription: prenatal vitamins, vitamins with fluoride and single-entity vitamins.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms that are determined to not be a Covered Health Service.
14. Prescription Drug Products when prescribed to treat infertility.
15. Compound drugs which contain any non-covered ingredients and compounds which do not contain at least one ingredient that requires a prescription. Compound drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available pharmaceutical product. Other coverage rules may apply.
16. Drugs available over-the-counter that do not require a prescription by federal or state law before being dispensed except for certain preventive OTC drugs – aspirin, fluoride, and folic acid – that require a prescription for coverage.
17. Yohimbine.
18. Mifeprex.
19. Blood or blood plasma products except for hemophilia factors.
20. Growth hormone used for the treatment of short stature in the absence of identified sickness or injury.
21. Nutritional supplements, except for those specifically identified as included under the plan. Contact CVS Caremark for a list of covered supplements.

22. Any Prescription Drug Product that is therapeutically equivalent to an OTC drug on CVS Caremark's OTC equivalent list. Prescription Drug Products that compromise components that are available in OTC form or an equivalent.
23. 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) such as; Jublia, Absorica, Nascobal, Kerydin, Zipsor, Aplenzin, Sitavig, Xerese, and Zyflo. Please note that changes to this list can be made quarterly.

FREQUENTLY ASKED QUESTIONS- PRESCRIPTION DRUG

This section will help you understand your medication choices and make informed decisions, plus it will help you understand which questions to ask your Doctor or Pharmacist.

Q1: Does this mean I can only go to CVS Pharmacy® for my prescriptions?
A1: This does NOT mean members will have to go to CVS Pharmacy for their prescriptions. CVS Caremark has a broad pharmacy network. Members and their covered dependent(s) can continue to use local retail and/or chain pharmacies to obtain their prescription medications. Use CVS Caremark's pharmacy locator tool to find a network pharmacy near you. See the following questions for specialty medications.

Q2: Where can I go for more information?
A2: Visit the CVS Caremark website at info.caremark.com/shbp or call:

CVS Caremark Customer Care	844-345-3241
CVS Specialty®:	866-845-6786
CVS Prior Authorization for Physicians	866-231-6377
CVS Prior Authorization for Specialty Drugs	866-231-8371

Q3: What is a preferred drug list?
A3: The CVS Caremark preferred drug list for the State Health Benefit Plan (SHBP) is a list of U.S. Food and Drug Administration (FDA) approved prescription drugs developed by CVS Caremark to provide coverage for SHBP members. You may pay more out of pocket under your plan for non-preferred drugs (those not listed as preferred on the preferred drug list) than you would for preferred drugs (those listed as preferred on the preferred drug list).

Q4: How do I use my preferred drug list and what are tiers?
A4: Your preferred drug list has different levels of payment, or tiers, for preferred and non-preferred medicines. You may pay:

$	Tier 1	Lowest Co-insurance for Generic drugs, and some select Brand-name drugs
$$	Tier 2	Higher Co-insurance for preferred drugs, mostly Brand-name drugs
$$$	Tier 3	Highest Co-insurance for non-preferred drugs, mostly Brand-name drugs

Your doctor may be able to help you save money by prescribing Generic and preferred Brand-name drugs, if appropriate, on the preferred drug list. So be sure to bring a copy of the abbreviated preferred drug list with you on every visit to your doctor. You can print a copy of the abbreviated preferred drug list from info.caremark.com/shbp. **Please note:** The list does not contain a complete list of preferred and non-referred drugs. It only lists the most commonly prescribed drugs. For more information, visit info.caremark.com/shbp to check the price and coverage of medications under your plan. You can also call CVS Caremark Customer Care at 844-345-3241.

Q5: Will the 2021 preferred drug list be different from the current preferred drug list that I have now?
A5: Yes. Effective January 1, 2021, your plan's preferred drug list (sometimes called a formulary) will have changes. As a result, some preferred medications may become non-preferred, and vice versa. With CVS Caremark, "Tier 1" will include all Generic drugs and some select Brand-name drugs, "Tier 2" will include all preferred drugs, which are mostly Brand-name drugs, and "Tier 3" will include all non-preferred drugs, which is mostly Brand-name drugs. It is important to note that some medications may move from one tier (Co-insurance level) to another. Depending on whether the medication is moving to a higher or lower tier, the amount you pay for that medication may increase or decrease. Visit info.caremark.com/shbp to view your new preferred drug list and find out which medications are preferred. If you are taking a drug that is about to become non-preferred, you may want to talk to your doctor about a lower-cost option.

Q6: Will the preferred drug list ever change?
A6: CVS Caremark makes updates to its preferred drug list on an ongoing basis. Changes can be made to the preferred drug list on a quarterly basis.

Q7: Will I be informed if my drug changes status on the drug list?
A7: Yes. CVS Caremark will mail a notification letter to you if your drug changes tier status and results in a higher Co-insurance cost to you at any point during the year.

Q8: Are any drugs excluded from my preferred drug list?
A8: The only prescription drugs excluded from your preferred drug list are drugs that fall under coverage areas which are not covered by your benefit design; such as drugs used for cosmetic purposes, drugs for weight loss, or drugs covered under the medical benefit through your medical claims administrator. Please refer to your Summary Plan Document (SPD) for additional information about non-covered drugs.

Q9: What is a 90-day retail pharmacy, and how can I find out if the pharmacy I go to is in that 90-day retail network?
A9: Getting up to a 90-day supply at a retail pharmacy is a feature of your prescription benefit, managed by CVS Caremark. With it, you have two ways to get up to a 90-day supply of your maintenance medicine (a medicine you take on an ongoing basis). You can conveniently fill those prescriptions either through CVS Caremark Mail Service Pharmacy™ or at a participating 90-day retail pharmacy. The 90-day retail network is a smaller collection of network pharmacies which are willing to provide a 90-day supply of your maintenance medications at a discounted rate to our members. To locate one, visit info.caremark.com/shbp. You can also locate participating pharmacies by calling CVS Caremark at 844-345-3241. You can use a retail network pharmacy that isn't in the 90-day network to get your 90-day supply of maintenance medications too, but your Co-insurance will be higher than what you would pay if you used one of the pharmacies in the 90-day retail network.

Q10: How do I start using CVS Caremark Mail Service Pharmacy?
A10: You can choose one of four easy ways:

- Phone: Call CVS Caremark Customer Care at 844-345-3241.
- Online: Visit info.caremark.com/shbp to register and sign in. Follow the guided steps to request a prescription. Once we have your information, we will contact your doctor for a 90-day prescription of your current medicine.
- Fax: Prescriber can fax a mail service order form to 1-800-378-0323.
- Mail: Fill out and return a mail service order form. You can download one at info.caremark.com/shbp, or you can obtain one from CVS Caremark Customer Care at 844-345-3241.

Q11: Which medications can I fill through the CVS Caremark Mail Service Pharmacy?
A11: Mail service is a convenient way to have 90-day supplies of your long-term medications shipped to you at no added cost. Mail service can save you both time and money—you do not have to worry about making a trip to the pharmacy every 31 days, and 90-day supplies typically cost less than three 31-day supplies. For more information, call CVS Caremark Customer Care.

Q12: Can I get a 90-day supply of my long-term medications at retail and at CVS Caremark?
A12: Yes.

Q13: Where do I register for CVS Caremark pharmacy services?
A13: Go to info.caremark.com/shbp.

Q14: How long does it take to receive my medications that I order through CVS Caremark mail service?
A14: For new prescriptions, it can take up to 10 days from the day you submit your order for delivery of your medication. Refills are usually delivered within seven days of placing your order. Although CVS Caremark

processes the orders within a day or two, the exact delivery day is dependent on the U.S. Postal Service.

Q15: Is there an additional charge for shipping and handling?
A15: No. Medications are shipped by standard service at no cost to you. Express shipping is also available for an additional fee.

Q16: How can I check the status of my refill order?
A16: You can check the status of your mail order refill for traditional medications by signing on to Caremark.com. Click "My Account" on the top right of the page, then click "Prescription History and Order Status." You can also call CVS Caremark Customer Care at 844-345-3241.

Q17: Will I be reminded when it's time to refill?
A17: Yes. You can sign up for refill reminders in one of three ways:

- Go online to info.caremark.com/shbp.
- Use the CVS Caremark mobile app.
- Call Customer Care at 844-345-3241.

Q18: What if I use a pharmacy that is not in the CVS Caremark network?
A18: If you choose to use a pharmacy that doesn't participate in the CVS Caremark retail network, you'll be charged the full cost for the medicine and you'll need to send a claim form to CVS Caremark for reimbursement. Under your plan, your reimbursement will be based on the cost you would have paid if you used a participating retail pharmacy, minus your applicable deductible and/or Co-insurance. Be sure to complete the entire claim form, attach the sales receipt showing the price you paid, and send them to CVS Caremark at the address on the form. To download a claim form, log in info.caremark.com/shbp and follow the link to print a form. Forms are also available by calling the CVS Caremark Customer Care at the number on your Anthem Member ID card.

Q19: How can I check that my current pharmacy is in the CVS Caremark Retail Pharmacy Network?
A19: You can visit info.caremark.com/shbp. You can also call CVS Caremark Customer Care at 844-345-3241.

Q20: How can I find out how much my cost is going to be?
A20: You can find out the cost of your drugs by visiting info.caremark.com/shbp or by calling the CVS Caremark Customer Care at 844-345-3241.

Q21: What if I want to speak with a pharmacist?
A21: You can speak to a pharmacist 24 hours a day, seven days a week, by calling the CVS Caremark Customer Care at 844-345-3241. When you call, you may be asked several questions to verify your identity.

Q22: What can I do on the CVS Caremark website?
A22: You may access the CVS Caremark website from a link on the SHBP website www.shbp.georgia.gov or go to info.caremark.com/shbp to get information about your plan, find participating retail pharmacies near you and see how much certain medicines will cost. You can go to info.caremark.com/shbp to also quickly refill mail service prescriptions, receive timely medication alerts, find potential lower-cost options available under your plan, check order status and ask questions of a pharmacist online. In order to get information specifically about your SHBP plan, you'll need to register first. Have your new Anthem Member ID card handy when you sign up.

Q23: How do I download the CVS Caremark mobile app?
A23: Visit your smartphone's or tablet's market or store and search for "CVS Caremark." It's free to download and use.

Q24: What is a prior authorization (PA)?
A24: Prior authorization is administered by CVS Caremark to determine whether your use of certain

medications meets your plan's conditions of coverage. In some cases, a prior authorization may be necessary to determine whether a prescription can be covered under your plan. If your prescription requires prior authorization, your doctor can initiate the prior authorization review by calling CVS Caremark at 866-231-6377. CVS Caremark will inform you and your doctor in writing of the outcome.

Q25: Can I find out ahead of time if a medication may need a prior authorization?
A25: Yes. Go to info.caremark.com/shbp and check the cost of your drug. By checking the cost of your drug, you will also be informed of whether a prior authorization or any other requirements are needed for your medication. You may also check the Preferred Drug List posted on the website for your drug which shows any edits required.

Q26: What is a specialty pharmacy?
A26: A specialty pharmacy provides injectable, oral and infused medicines. These complex and costly medicines usually require special storage and handling and may not be readily available at a local pharmacy. Sometimes these medications have side effects that require monitoring by a trained pharmacist or nurse. CVS Specialty focuses on providing these medicines while offering excellent customer service and clinical support to you and your caregivers.

Q27: Why should I use CVS Specialty for my specialty medicines?
A27: As you may know, the cost of prescription drugs has been rising dramatically over the last several years. That's especially true of specialty medicines. By using CVS Specialty for specialty drugs, your prescription drug benefit can offset some of these high costs.

Q28: How do I get started with CVS Specialty?
A28: You can call us at 866-845-6786 and we will help get you started. With your permission, we will fax your doctor to request a new prescription. Or, your doctor can initiate this by sending CVS Caremark your prescription electronically, by fax or by phone. After your doctor provides the prescription to CVS Caremark, one of our patient care representatives will call you to arrange a convenient time to deliver your medicine. CVS Specialty will provide an expected delivery time after CVS Caremark receives the prescription from your doctor and all shipping requirements are met. CVS Caremark uses scheduled delivery service companies at no cost to you, and all packages include most of the supplies you'll need to properly administer your medicines, also at no charge.

Q29: How much medicine can I receive per specialty prescription?
A29: You may receive up to a 31-day supply at a time of specialty medicine.

Q30: What if I have questions about my specialty medications?
A30: Visit www.cvsspecialty.com anytime or call CVS Specialty at 866-845-6786 to speak with a representative. At CVS Specialty, you have access to a team of pharmacists and nurses.

Q31: Is there an extra cost to use CVS Specialty services?
A31: No. CVS Specialty is part of your prescription drug benefit.

Q32: Can I order all my medications from CVS Specialty?
A32: No. CVS Specialty dispenses only specialty medicines. Any other non-specialty prescriptions sent to CVS Specialty will be transferred to CVS Caremark mail service.

PRESCRIPTION DRUG GLOSSARY AND DEFINITIONS

This section defines the terms used throughout this Outpatient Prescription Drug Rider.

Ancillary Charge: A charge that, in addition to the Co-insurance, you are required to pay if a covered Brand-name Prescription Drug Product is dispensed at you or your physician's request, when a chemically equivalent generic Prescription Drug Product is available. The Ancillary Charge is calculated as the difference between the cost of the Brand-name Prescription Drug Product and cost of the Generic Prescription Drug Product, based on CVS Caremark retail Network rates.

Brand-name: A Prescription Drug Product that: (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) CVS Caremark identifies as a Brand-name product based on available data resources – including, but not limited to, Medispan– that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as "Brand-name" by the manufacturer, Pharmacy or your Physician may not be classified as Brand-name by CVS Caremark.

Covered Person: Either the Enrolled Member or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" throughout this chapter are references to a Covered Person.

Co-insurance: A percentage of the total cost of the claim that must be paid by the Member.

Designated Pharmacy: A pharmacy that has entered into an agreement with CVS Caremark, or with an organization contracting on its behalf, to provide specific Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Full Retail Cost: Also known as Usual and Customary Charges. This is the amount that a Pharmacist would charge a cash-paying customer for a prescription.

Generic: A Prescription Drug Product that: (1) is chemically equivalent to a Brand-name drug; or (2) CVS Caremark identifies as a Generic product based on available data resources – including, but not limited to, Medispan – that classify drugs as either Brand-name or Generic based on a number of factors. You should know that all products identified as a "Generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by CVS Caremark.

Mail Order: Allows members requiring maintenance medications the convenience of having maintenance medications delivered to the home or office by US mail, a common carrier or a delivery service.

Member or Covered Member: People, including the Covered Person and his/her Dependents, who have met the eligibility requirements, applied for coverage, enrolled in the Plan, and paid the necessary contribution or premium for such coverage in the manner required by the Plan Administrator.

Network Pharmacy: A pharmacy that has:

- Entered into an agreement with CVS Caremark or its designee to provide Prescription Drug Products to Covered Persons
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products
- Been designated by CVS Caremark as a Network Pharmacy

A Network Pharmacy can be a participating Retail, Home Delivery or Specialty Designated Pharmacy.

New Prescription Drug Product: A Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

- The date it is assigned to a tier by the Plan's Pharmacy Benefits Administrator's Prescription Drug List Management Committee, or
- December 31st of the following plan year

Prescription Drug Cost: The rate CVS Caremark has contracted with the Network Pharmacies on behalf of SHBP, including a dispensing fee and any sales tax, if applicable, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL): A PDL is a list of FDA-approved Brand-name and Generic medications. The PDL is one way you can find out the tier status and specific rules linked to your medication. The PDL lists the most commonly prescribed medications for certain conditions.

Prescription Drug Product: A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a prescription. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver or a skilled caregiver in the case of certain Specialty medications.

For the purpose of Benefits under the plan, this definition includes but is not limited to:

- Inhalers (with spacers)
- Insulin

The following diabetic supplies:

- Insulin syringes with or without needles
- Urine/Blood Test Strips & Tapes
- Lancets
- Blood Glucose Testing monitors
- Continuous Glucose Monitor/Transmitters/Sensors

Preventive Care Medications: The medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Co-insurance) as required by applicable law under any of the following:

- with respect to infants, children and adolescents, evidence-informed preventive care provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

You may determine whether a drug is a Preventive Care Medication at info.caremark.com/shbp or by calling CVS Caremark Customer Care at the toll-free telephone number on your Anthem Member ID card.

Specialty Prescription Drug Product: A Prescription Drug Product that is generally a high-cost, oral or self-injectable biotechnology drug used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drugs at info.caremark.com/shbp or by calling the CVS Caremark Customer Care number on your Anthem Member ID card.

Usual and Customary Charge: The amount that a Pharmacist would charge a cash-paying customer for a prescription.

End of Pharmacy Benefits Administrator

Legal Notices 2021

About the Following Notices

The following important legal notices are also posted on the State Health Benefit Plan (SHBP) website at www.shbp.georgia.gov under Plan Documents:

Penalties for Misrepresentation

If a SHBP participant misrepresents eligibility information when applying for coverage during change of coverage or when filing for benefits, the SHBP may take adverse action against the participants, including but not limited to terminating coverage (for the participant and his or her dependents) or imposing liability to the SHBP participants for fraud (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

To avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician/Provider (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 children, you may also designate a pediatrician as the PCP. For information on how to select a PCP, and for a list of participating PCP's, call the telephone number on your Member Identification Card. Access to Obstetrical and Gynecological (OB/GYN) 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, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the telephone number on your Member Identification Card.

Access to Obstetrical and Gynecological (OB/GYN) 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, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, call the telephone number on your Member Identification Card.

HIPAA Special Enrollment Notice

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

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

thirty-one (31) days after the marriage or adoption, or placement for adoption (or within 90 days for a newly eligible dependent child).

Eligible Covered Persons and Dependents may also enroll under two additional circumstances:
- The Covered Person's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Covered Person or Dependent becomes eligible for a subsidy (State Premium Assistance Program).

NOTE: The Covered Person or Dependent must request Special Enrollment within sixty (60) days of the loss of Medicaid/CHIP or of the eligibility determination. To request Special Enrollment or obtain more information, call SHBP Member Services at 1-800-610-1863 or visit the SHBP Enrollment Portal: https://myshbp.adp.ga.com.

Women's Health and Cancer Rights Act of 1998
The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other medical and surgical benefits under your Plan Option. Following cancer surgery, the SHBP covers:
- All stages of reconstruction of the breast on which the mastectomy has been performed
- Reconstruction of the other breast to achieve a symmetrical appearance
- Prostheses and mastectomy
- Treatment of physical complications of mastectomy, including lymphedema

NOTE: Reconstructive surgery requires prior approval, and all Inpatient admissions require prior notification. For more detailed information on the mastectomy-related benefits available under your Plan option, call the telephone number on your Member Identification Card.

Newborns' and Mothers' Health Protection Act of 1996
The Plan complies with the Newborns' and Mothers' Health Protection Act of 1996.

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 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, as applicable).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT NOTICE OF INFORMATION PRIVACY PRACTICES
Georgia Department of Community Health
State Health Benefit Plan Notice of Information Privacy Practices
Revised June 28, 2018

The purpose of this notice is to describe how medical information about you, which includes your personal information, may be used and disclosed and how you can get access to this information. Please review it carefully.

The Georgia Department of Community Health (DCH) and the State Health Benefit Plan Are Committed to Your Privacy. DCH understands that your information is personal and private. Certain DCH employees and companies hired by DCH to help administer the Plan (Plan Representatives) use and share your personal and private information in order to administer the Plan. This information is called "Protected Health Information" (PHI), and includes any information that identifies you or information in which there is a reasonable basis to believe can be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, and payment for those services. This notice tells how your PHI is

used and shared by DCH and Plan Representatives. DCH follows the information privacy rules of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Only Summary Information is Used When Developing and/or Modifying the Plan.
The Board of Community Health, which is the governing Board of DCH, the Commissioner of DCH and the Chief of the Plan administer the Plan and make certain decisions about the Plan. During those processes, they may review certain reports that explain costs, problems, and needs of the Plan. These reports never include information that identifies any individual person. If your employer is allowed to leave the Plan entirely, or stop offering the Plan to a portion of its workforce, DCH may provide Summary Health Information (as defined by federal law) for the applicable portion of the workforce. This Summary Health Information may only be used by your employer to obtain health insurance quotes from other sources and make decisions about whether to continue to offer the Plan. Please note that DCH, Plan Representatives, and your employer are prohibited by law from using any PHI that includes genetic information for underwriting purposes.

Plan "Enrollment Information" and "Claims Information" are Used in Order to Administer the Plan. PHI includes two kinds of information, "Enrollment Information" and "Claims Information". "Enrollment Information" includes, but is not limited to, the following types of information regarding your plan enrollment: (1) your name, address, email address, social security number and all information that validates you (and/or your Spouse and Dependents) are eligible or enrolled in the Plan; (2) your Plan enrollment choice; (3) how much you pay for premiums; and (4) other health insurance you may have in effect. There are certain types of "Enrollment Information" which may be supplied to the Plan by you or your personal representative, your employer, other Plan vendors or other governmental agencies that may provide other benefits to you. This "Enrollment Information" is the only kind of PHI your employer is allowed to obtain. Your employer is prohibited by law from using this information for any purpose other than assisting with Plan enrollment.

"Claims Information" includes information your health care providers submit to the Plan. For example, claims information may include medical bills, diagnoses, statements, x-rays or lab test results. It also includes information you may submit or communicate directly to the Plan, such as health questionnaires, biometric screening results, enrollment forms, leave forms, letters and/or telephone calls. Lastly, it includes information about you that may be created by the Plan. For example, it may include payment statements and/or other financial transactions related to your health care providers.

Your PHI is Protected by HIPAA. Under HIPAA, employees of DCH and employees of outside companies and other vendors hired or contracted either directly or indirectly by DCH to administer the Plan are "Plan Representatives," and therefore must protect your PHI. These Plan Representatives may only use PHI and share it as allowed by HIPAA, and pursuant to their "Business Associate" agreements with DCH to ensure compliance with HIPAA and DCH requirements.

DCH Must Ensure the Plan Complies with HIPAA. DCH must make sure the Plan complies with all applicable laws, including HIPAA. DCH and/or the Plan must provide this notice, follow its terms and update it as needed. Under HIPAA, Plan Representatives may only use and share PHI as allowed by law. If there is a breach of your PHI, DCH must notify you of the breach.

Plan Representatives Regularly Use and Share your PHI in Order to Administer the Plan. Plan Representatives may verify your eligibility in order to make payments to your health care providers for services rendered. Certain Plan Representatives may work for contracted companies assisting with the administration of the Plan. By law, these Plan Representative companies also must protect your PHI.

HIPAA allows the Plan to use or disclose PHI for treatment, payment, or health care operations. Below are examples of uses and disclosures for treatment, payment and health care operations by Plan Representative Companies and PHI data sharing.

<u>Claims Administrator Companies:</u> Plan Representatives process all medical and drug claims; communicate with the Plan Members and/or their health care providers.

Wellness Program Administrator Companies: Plan Representatives administer Well-Being programs offered under the Plan; and communicate with the Plan Members and/or their health care providers.

Actuarial, Health Care and /or Benefit Consultant Companies: Plan Representatives may have access to PHI in order to conduct financial projections, premium and reserve calculations, and financial impact studies on legislative policy changes affecting the Plan.

State of Georgia Attorney General's Office, Auditing Companies and Outside Law Firms: Plan Representatives may provide legal, accounting and/or auditing assistance to the Plan.

Information Technology Companies: Plan Representatives maintain and manage information systems that contain PHI.

Enrollment Services Companies: Plan Representatives may provide the enrollment website and/or provide customer service to help Plan Members with enrollment matters.

NOTE: Treatment is not provided by the Plan, but we may use or disclose PHI in arranging or approving treatment with providers.

Under HIPAA, all employees of DCH must protect PHI and all employees must receive and comply with DCH HIPAA privacy training. Only those DCH employees designated by DCH as Plan Representatives for the SHBP health care component are allowed to use and share your PHI.

DCH and Plan Representatives May Make Uses or Disclosures Permitted by Law in Special Situations. HIPAA includes a list of special situations when the Plan may use or disclose your PHI without your authorization as permitted by law. The Plan must track these uses or disclosures. Below are some examples of special situations where uses or disclosures for PHI data sharing are permitted by law. These include, but are not limited to, the following:

Compliance with a Law or to Prevent Serious Threats to Health or Safety: The Plan may use or share your PHI in order to comply with a law or to prevent a serious threat to health and safety.

Public Health Activities: The Plan may give PHI to other government agencies that perform public health activities.

Information about Eligibility for the Plan and to Improve Plan Administration: The Plan may give PHI to other government agencies, as applicable, that may provide you or your dependents benefits (such as state retirement systems or other state or federal programs) in order to get information about your or your dependent's eligibility for the Plan, to improve administration of the Plan, or to facilitate your receipt of other benefits.

Research Purposes: Your PHI may be given to researchers for a research project when the research has been approved by an institutional review board. The institutional review board must review the research project and its rules to ensure the privacy of your information.

Plan Representatives Share Some Payment Information with the Employee. Except as described in this notice, Plan Representatives are allowed to share your PHI only with you and/or with your legal personal representative. However, the Plan may provide limited information to the employee about whether the Plan paid or denied a claim for another family member.

You May Authorize Other Uses of Your PHI. Plan Representatives may not use or share your PHI for any reason that is not described in this notice without a written authorization by you or your legal representative. For example, use of your PHI for marketing purposes or uses or disclosures that would constitute a sale of PHI are illegal without this written authorization. If you give a written authorization, you may revoke it later.

You Have Privacy Rights Related to Plan Enrollment Information and Claims Information that Identifies You.
Right to Inspect and Obtain a Copy of your Information, Right to Ask for a Correction: You have the right to obtain a copy of your PHI that is used to make decisions about you. If you think it is incorrect or incomplete, you may contact the Plan to request a correction.

Right to Ask for a List of Special Uses and Disclosures: You have the right to ask for a list of all special uses and disclosures.

Right to Ask for a Restriction of Uses and Disclosures or for Special Communications: You have the right to ask for added restrictions on uses and disclosures, but the Plan is not required to agree to a requested restriction, except if the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and pertains solely to a health care item or service that you or someone else on your behalf has paid in full. You also may ask the Plan to communicate with you at a different address or by an alternative means of communication in order to protect your safety.

Right to a Paper Copy of this notice and Right to File a Complaint: You have the right to a paper copy of this notice. Please contact the SHBP Member Services Center at 1-800- 610-1863 or you may download a copy at www.shbp.georgia.gov. If you think your HIPAA privacy rights may have been violated, you may file a complaint. You may file the complaint with the Plan and/or the U.S. Department of Health & Human Services, Office of Civil Rights, Region IV. You will never be penalized by the Plan or your employer for filing a complaint.

Addresses to File HIPAA Complaints:
Georgia Department of Community Health
SHBP HIPAA Privacy Unit
P.O. Box 1990
Atlanta, GA 30301
1-800-610-1863

U.S. Department of Health & Human Services
Office for Civil Rights
Region IV
Atlanta Federal Center
61 Forsyth Street SW
Suite 3B70
Atlanta, GA 30303-8909
1-877-696-6775

For more information about this Notice, contact:
Georgia Department of Community Health
State Health Benefit Plan
P.O. Box 1990
Atlanta, GA 30301
1-800-610-1863

Summaries of Benefits and Coverage
Summaries of benefits and coverage describe each Plan Option in the standard format required by the Affordable Care Act. These documents are posted here: https://shbp.georgia.gov/plan-options-programs/2021-summary-benefits-and-coverage. To request a paper copy, please contact SHBP Member Services at 800-610-1863.

Georgia Law Section 33-30-13 Notice:
SHBP actuaries have determined that the total cost of coverage (which includes the cost paid by the State and the cost paid by members) under all options is 0% higher than it would be if the Affordable Care Act provisions did not apply.