University of Cincinnati - W51074 - 20220101 - Retiree - W0BC	
Indemnity Plan Design	
Plan Information	
Plan Name	University of Cincinnati - W51074 - 20220101 - Retiree - W0BC
Anthem Account	Anthem Local Accounts
Plan Design	Indemnity Plan Design
My Incentive	No
Qualified Health Expense (QHE) Product	No
Classification	Self-Insured Local Plan Design
Effective Date	2022-01-01
Account Prefix	TUC
Group Name	University of Cincinnati
Package/Contract Code	W0BC
Group/Case Number	W51074
Customer Service Telephone Number	1-844-249-5372
Customer Service Hours of Operation - Monday to Friday	8am to 6pm
Service Center Mailing Address	PO Box 105187 Atlanta GA 30348-5187 *Providers send claims to their local plan.*
Provider Directory/Member Portal Website	www.anthem.com
Network	Blue Traditional
ID card generation	Subscriber level (all ID cards have name of subscriber)
Plan name to appear on booklet cover and special logo info	University of Cincinnati - W51074 - 20220101 - Retiree - W0BC
HCR Status	Exempt
Eligibility Determination	
Children Max Age	26
Children Max Age Rule	End of Month
Students Max Age	26
Students Max Age Rule	End of Month
Solicitation of Student Eligibility	Determined by Account
Newborn Eligibility	Coverage eligibility begins at birth. If dependent is not enrolled claim will be denied.
Contact for Enrollment update	Enrollment is updated by HR. The Employee should call 513-556-6381 to enroll dependent. *Member must enroll newborn within 31 days. Anthem can extend benefits to the newborn once enrollment is received, retroactive to the dependent's effective date.*
Disabled Dependents	Covered
Solicitation of Disabled Dependents Eligibility Determination	Anthem
International Employees	Covered
Domestic Partners (same sex)	Covered *Domestic Partner Children are not covered*

Eligibility Determination	
Domestic Partners (opposite sex)	Covered *Domestic Partner Children are not covered*
Sponsored Dependent (Class II)	Not Covered
COBRA	Not Covered
Pre-65 Retirees	Covered
Post-65 Retirees	Covered

General Information	
Benefit Period	Calendar Year
Timely Filing	90 Days *From the date of service.* *Participating Providers to follow contractual filing limitations.*
Foreign Claims	Covered *Foreign claims are covered at either the negotiated discount amount or charges using the current exchange rates.*
Benefit Booklets created by	Anthem
Performance Guarantee Account	Yes

Vendor/Contact Information	
AIM Specialty Health	Not Purchased
Autism Spectrum Disorder	Not Selected
Behavioral Health/Substance Abuse Vendor Name and Contact	Anthem Behavioral Health 1-866-643-7087
Benefit Office Name and Contact	University of Cincinnati HR 513-556-6381
COBRA Vendor Name and Contact	Chard Snyder: Kevin Bricking Client Relationship Manager kevin.bricking@ascensus.com P 513-204-6737 Danielle Thomas COBRA Coordinator, Benefit Continuation Services Danielle.Thomas@Ascensus.com P 833-212-1988 Ext 23342
Dental Vendor Name and Contact	Delta Dental of Ohio: 1-800-524-0149
eConsult	Opt In
Eligibility Vendor Name and Contact	University of Cincinnati HR 513-556-6381
LiveHealth Online (LHO) Vendor Contact	www.livehealthonline.com
Managed Care Model Name	CCM
Managed Care Vendor Name and Contact	Anthem Medical Management 1-866-643-7087
Pharmacy Drug Vendor Name and Contact	Anthem Prescription Drug Plan Member Inquiries: 1-833-288-4294 Pharmacist Phone Number 1-833-296-5037
Pre-Cert List	Enterprise Standard
Anthem Medical Management System	ACMP
Specialty Pharmacy Vendor Name and Contact	Anthem Prescription Drug Plan 1-833-288-4294

Vendor/Contact Information	
Medical Pharmacy Vendor Name and Contact	Anthem Prescription Drug Plan 1-833-293-0659
Subrogation Vendor Name and Contact	Anthem
Standard Embedded Comprehensive Eye Exam	Opt Out

Prior Carrier information	
Prior Carrier Name and Contact	Humana1-800-601-5031
Prior Carrier Deductible Credit	No
History conversion required, Lifetime Maximum	Yes
History conversion required, Deductible credit	No
History conversion required, Out-of-Pocket credit	No

Integration with Other vendors	
Pharmacy Integration	No
3rd Party Benefit integration	No
Accumulation history from prior carrier	No
FSA Integration	Indicate if there is any integration with FSA (i.e. Claims rollover, etc…)

Coordination of Benefits (COB) and Medicare	
COB Method	Pay & Pursue
COB Solicitation, COB Information is solicited	Annually
COB Solicitation, COB Option Selected	A- Pay and Pursue 12 months
COB Solicitation-COB information update	Call the Customer Service Center directly and speak to a representative or via IVR process Complete and return the COB questionnaire Online via the web
COB Processing Provider Rule	Par Providers or OON providers are processed based on the in-Network Level of Benefits.
COB Processing Payment Rule	Option 1: Hard Non-Duplication: Determine what Anthem would have paid had we been the primary carrier then subtract the other carrier's paid amount.
COB Processing Gender Birthday Rule	Birthday Rule Applies
Medicare Method	Pursue & Pay
Medicare Processing	Option 4: Medicare is carved out prior to determining Anthem's benefit, but Medicare claims are not subject to deductible, copayment or coinsurance. If Medicare denies and services are covered under Anthem's group benefits then Anthem will pay.
Medicare Opt Out Processing	When a member or a provider opts out of Medicare we will process the claim as if Medicare made a payment
National Medicare Crossover	Applies - Medicare secondary claims will automatically transmit electronically from the provider to Anthem

Coordination of Benefits (COB) and Medicare

Primacy Rules

The following rules determine the order in which benefits are payable:

1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This would include Medicare in all cases, except when the law requires that this plan pays before Medicare.
2. A plan which covers you as a subscriber pays before a plan which covers you as a dependent. But, if you are retired and eligible for Medicare, Medicare pays (a) after the plan which covers you as a dependent of an active employee, but (b) before the plan which covers you as a retired subscriber.
3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits. Exception to rule 3: For a dependent child of parents who are divorced or separated, the following rules will be used in place of Rule 3:
   a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.
   b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
      i. The plan which covers that child as a dependent of the parent with custody.
      ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).
      iii. The plan which covers that child as a dependent of the parent without custody.
      iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).
   c. Regardless of a and b above, if there is a court decree which establishes a parent's financial responsibility for that child's health care coverage, a plan which covers that child as a dependent of that parent pays first.
4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employees, provision 6 applies.
5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the order of benefit determination provisions of This Plan, this rule will not apply.
6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

APPEALS - Complaints, Grievances and Appeals (CGA)

Exempt	
Claims Fiduciary	Anthem
Appeals Address	Anthem Appeals PO Box 105568 Atlanta GA 30348
Prospective Appeals, Days to File Appeal - Mandatory Level I	The member has 180 days to file a mandatory first level of appeal from the date of the adverse determination.
Prospective Appeals, Days to File Appeal - Voluntary Level II	The member has 60 days to file a voluntary second level of appeal from the date of the first level of appeal adverse determination.
Prospective Appeals Decision Time Frame - Expedited/Concurrent	Anthem will respond within 72 hours from request of appeal (specialty match).
Prospective Appeals Decision Time Frame - Mandatory Level I	Anthem will respond within 30 calendar days from request of appeal (specialty match).
Prospective Appeals Decision Time Frame - Voluntary Level II	Anthem will respond within 30 calendar days from request of appeal.
Retrospective Appeals, Days to File Appeal - Mandatory Level I	The member has 180 days to file a mandatory first level of appeal from the date of the adverse determination.
Retrospective Appeals, Days to File Appeal - Voluntary Level II	The member has 60 days to file a voluntary second level of appeal from the date of the first level of appeal adverse determination.

APPEALS - Complaints, Grievances and Appeals (CGA)	
Exempt	
Retrospective Appeals Decision Time Frame - Mandatory Level I	Anthem will respond within 60 calendar days from request of appeal (specialty match).
Retrospective Appeals Decision Time Frame - Voluntary Level II	Anthem will respond within 60 calendar days.
External Appeals, Note	All External Appeals are voluntary: If the outcome of the mandatory first level appeal is adverse to the member, they may be eligible for an independent External Review pursuant to federal law. To be eligible, the appeal must be regarding a medical judgment or rescission.
External Appeals, Days to File Appeal	The member has four months to file a voluntary external appeal from the day the first level denial is received.
External Appeals, Days to File Appeal - Expedited/Concurrent	For pre-service claims involving urgent/ concurrent care, the member may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process.
External Appeal Decision Time Frame - Standard	'Independent Review Organization (IRO) has 30 days from receipt of the appeal from Anthem.
External Appeal Decision Time Frame - Urgent/Expedited	Independent Review Organization (IRO) has 72 Hours from receipt of the appeal from Anthem.

ENTERPRISE MANAGED CARE PRIOR AUTHORIZATION REQUIREMENTS	Enterprise Standard
Precert Rules	
Precert Notes	In order to avoid denial of services for hospital/medical benefits please call before receiving services or no later than 2 business days after admission for an emergency admission. Global ANA Standard Pre-cert list posted separately on the NIC Site.
Penalty - No Precert on File	If claims are not pre-certified they will be denied for no pre-certification. Once information is received claims can be re-opened based on medical information provided.
Penalty - Not Medically Necessary	Any services or days found not to be medically necessary will not be covered.
Late Notice/Penalty Amount	$300
Inpatient Services	
Bariatric Buy Up Program	Not Purchased *If purchased, Bariatric surgeries require the use of a Blue Distinction Center of Excellence and the cases are handled in the National Blue Distinction Bariatric Care Management Department.*
Blue Distinction Tiered Orthopedic Benefit	Not Purchased *If purchased, procedures included: Total and Revision Knee Replacements, Total and Revision Hip Replacements, Spinal Discectomy, Spinal Decompressions, Primary and Revision Spinal Fusions. Use of a Blue Distinction Centers+ facility may be required to maximize member benefits.*
A.I.M. Specialty Health Services	
Anthem Cancer Quality Care Program	UM
Cardiology	UM
Genetic Testing	UM
MSK(Musculoskeletal)	UM
Radiation Therapy	UM
Radiology Benefit Management	UM
Sleep	UM
Surgical Gastrointestinal	UM
Surgical Shopper Clinical Review	UM
Specialty Pharmacy Services	
RX Site Of Care	Yes
Self Administered Drug Block - RDRC Program C (Medical Block)	Yes
Clinician Administered Drug Block - RDRC Program D (Pharmacy Block)	Yes
Quantity, Frequency And Dose - RDRC Program A	Yes
Clinical Equivalent - RDRC Program B	Yes

ABA Therapy	
ABA Therapy	Yes
Other	
Medical Specialty Drug Review	TBD(Yes)
Out-Of-Network Referrals	
Notes	Out of Network Services for consideration of payment at in-network benefit level (may be authorized, based on network availability and/or medical necessity.) Precert needed for childbirth if inpatient stay exceeds 48 hrs for normal delivery and 96 hrs after a cesarean delivery. Applies penalty per visit.
Global Precert Statement/Rules	Medicare and COB claims do not require prior authorization. Member is responsible for Precertification of services and would be liable for any penalties applied. Participating provider is responsible for Precertification of services and would be liable for any penalties applied. Bariatric surgery should be pre-certified/pre-authorized when the plan contains documentation of benefits or if surgical procedures for morbid obesity exist. The review applies to plans with steerage toward Blue Distinction Centers of Excellence for Bariatric Surgery or for management of care when steerage does not exist.
Medical Management Program	
Notes	Failure to comply with our Medical Management Program could result in benefit reductions and/or denial of services.

Deductible, Coinsurance, Maximums, & Pricing	
Copayment	**Indemnity**
Copayment Maximum - Individual	$400 Per Year Individual
Copayment Maximum - Family	N/A
Deductible	**Indemnity**
Deductibles - Individual	$100 Per Year Individual
Deductibles - Family	$200 Per Year Family
Deductible Standardly Applied - Non Routine Services	Yes
Deductible	
Common Accident Deductible	No
Accumulation Combination	Combined professional/institutional
Deductible - Accumulation Method	Family amount can be satisfied by any combination of family members but an individual would never satisfy more than their own individual amount. Embedded.
4th Quarter Deductible Carryover	No
Coinsurance	**Indemnity**
Coinsurance - Plan	80%
Coinsurance - Member Responsible	20%
Coinsurance Maximum - Individual	$400 Per Year Individual
Coinsurance Maximum - Family	N/A
Out of Pocket	**Indemnity**
Out of Pocket Maximum - Individual	$400 Per Year Individual
Out of Pocket Maximum - Family	N/A
Out of Pocket	
Accumulation Combination	Combined professional/institutional
Deductible and Coinsurance Included	The coinsurance and deductible apply towards the out-of-pocket maximum.
4th Quarter Coinsurance Carryover	No
Out of Pocket - Accumulation Method	Family amount can be satisfied by any combination of family members but an individual would never satisfy more than their own individual amount (embedded)
Out of Pocket Limit Exclusions	Non-covered services Services deemed not medically necessary by Medical Management and/or Anthem Penalties for non-compliance Charges over the allowed amount Co-payments
Pricing	
Non Participating fee negotiation vendor	Opt In
Pricing for Non Participating Professional Providers – Maximum Allowed Amount (MAA)	Local Plan Pricing

Pricing	
Pricing for Non-Participating Institutional Providers – Maximum Allowed Amount (MAA)	Local Plan Pricing
Pricing for Non Participating Professional Hospital Based Physician Services	Specific % of Medicare Allowed
Pricing for Non Participating Professional Hospital Based Physician Services - Value	175%
Supplemental Accident Benefit	N/A
Benefit Year Accumulation Type	N/A
Benefit Year maximum Accumulation Exclusions	All paid covered benefits will apply towards maximum unless specifically excluded
Portability of Coverage	Visit and dollar maximums should carry over when member changes package but maintains the same group number

Lifetime Maximum	Indemnity
Lifetime Maximum	$500,000 Per Lifetime Individual

Lifetime Maximum	
Lifetime Accumulation Method	LTM accumulation is shared between INN and OON
Lifetime Accumulation Exclusions	All paid covered benefits will apply towards LTM unless specifically excluded
Lifetime Maximum Benefit Restoration	No

Benefits

Benefit Notes

Any benefits with combined visit limits will count services on the same date of services as 1 visit, unless otherwise noted.
All services are subject to medical policy, unless otherwise noted.

Acupuncture	Indemnity[3]
Acupuncture Outpatient Professional	Not Covered
Acupuncture Office Professional	Not Covered

Allergy	Indemnity[3]
Allergy Treatment	Covered Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Allergy Testing	Covered Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Ambulance	Indemnity[3]
Air Ambulance *Air Ambulance will suspend for medical necessity.*	Covered Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Ground Ambulance	Covered Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Ambulatory Surgical Centers	Indemnity[3]
Ambulatory Surgical Center Institutional	Covered Covered At : 100% Deductible : No Copayment : N/A Limit : N/A

Anesthesia	Indemnity[3]
Anesthesia Inpatient Professional	Covered Covered At : 100% Deductible : No Copayment : N/A Limit : N/A

Anesthesia	Indemnity[3]
Anesthesia Outpatient Professional	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Anesthesia Office Professional	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A

ABA Therapy	Indemnity[3]
ABA Therapy Outpatient Institutional *Applied Behavioral Analysis (ABA) Therapy is covered* *Applied Behavioral Analysis (ABA) Therapy is classified as behavioral health*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
ABA Therapy Inpatient Professional *Applied Behavioral Analysis (ABA) Therapy is covered* *Applied Behavioral Analysis (ABA) Therapy is classified as behavioral health*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
ABA Therapy Outpatient Professional *Applied Behavioral Analysis (ABA) Therapy is covered* *Applied Behavioral Analysis (ABA) Therapy is classified as behavioral health*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
ABA Therapy Office Professional *Applied Behavioral Analysis (ABA) Therapy is covered* *Applied Behavioral Analysis (ABA) Therapy is classified as behavioral health*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Attention Deficit Disorders	Indemnity[3]
ADD/ADHD *Includes Autistic Disease, Intellectual Disability, Developmental Delays and Learning Disabilities*	**Covered - At the benefit level of the services billed** Limit : N/A

Bariatric Surgery	Indemnity[3]
Bariatric Surgery	**Not Covered**

Biofeedback	Indemnity[3]
Biofeedback Outpatient Professional	**Not Covered**
Biofeedback Office Professional	**Not Covered**

Blood Processing and Storage	Indemnity[3]
Blood *Processing and Storage*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Chiropractic Benefits	Indemnity[3]
Chiropractic Outpatient Professional *Includes all services performed by a chiropractor except Labs and X-Rays .*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 20 Visits Per Year
Chiropractic Office Professional *Includes all services performed by a chiropractor except Labs and X-Rays .*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 20 Visits Per Year

Dental Benefits	Indemnity[3]
Dental *Covered for treatment of an injury to sound and natural teeth.* *Treatment must begin within 90 days of the accident andtreatment completed within 12 months of the accident*	**Covered - At the benefit level of the services billed** Limit : N/A

Diabetes Maintenance	Indemnity[3]
Diabetes Education/Diabetic Nutritional Counseling Outpatient Institutional *Diabetic and Non- Diabetic Nutritional Counseling is covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Diabetes Education/Diabetic Nutritional Counseling Outpatient Professional *Diabetic and Non- Diabetic Nutritional Counseling is covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Diabetes Education/Diabetic Nutritional Counseling Office Professional *Diabetic and Non- Diabetic Nutritional Counseling is covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Diabetic Supply *Diabetic Supplies covered by pharmacy plan are not covered under medical - including lancets, syringes, insulin etc. Diabetic supplies not covered under Pharmacy are covered by the medical plan.* *Continuous Glucose Monitor continues to pay under medical.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Diagnostic X-ray, Lab, and Diagnostic Services (Non Routine)	Indemnity[3]
DXL Outpatient Institutional	Covered Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
DXL Inpatient Professional	Covered Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
DXL Outpatient Professional	Covered Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
DXL In Office	Covered Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
DXL Independent Lab	Covered Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Pre-surgical/Pre-admission testing	Covered Covered At : 100% Deductible : No Copayment : N/A Limit : N/A

Durable Medical Equipment	Indemnity[3]
Durable Medical Equipment *Purchase & Rental*	Covered Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Medical Supply	Covered Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Durable Medical Equipment	Indemnity[3]
Prosthetics and Orthotics	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Hearing Aid Services *Hardware: Hearing Aids* *Including exams and hearing aid accessories.*	**Not Covered**
Vision Hardware *For glasses or contact lenses following cataract surgery, refer to P&O benefit.*	**Not Covered**
Wigs/Toupees *Wigs/Toupees are subject to Medical Necessity.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 1 Units Per Lifetime

Emergency Care	Indemnity[3]
Emergency – Emergency Room (Institutional) *Prudent Layperson guidelines apply all services will be paid at the in-network level of benefit (accidental injury and medical emergency diagnoses pay as emergency).* *Yes-Apply Prudent Lay guidelines.*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Emergency – Emergency Room Physician *When Applicable Prudent Layperson guidelines apply (accidental injury and medical emergency diagnoses pay as emergency).*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Non-Emergency Medical Condition – Emergency Room (Institutional) *Applies to non-emergency Medical Condition diagnoses (as defined by Prudent Lay).*	**Not Covered**
Non-Emergency Medical Condition– Emergency Room Physician *Applies to non-emergency Medical Condition diagnoses (as defined by Prudent Lay).*	**Not Covered**

Foot Care	Indemnity[3]
Foot Care (Routine)	**Not Covered**

Gender Reassignment Surgery	Indemnity[3]
Gender Reassignment Surgery	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A

Hearing	Indemnity[3]
Hearing Exam (non-routine) Outpatient Professional *Includes non-routine hearing*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Hearing Exam (non-routine) Office Professional *Includes non-routine hearing*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Home Health/Home Infusion/PDN	Indemnity[3]
Home Health Care	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Home Infusion Therapy	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Private Duty Nursing *Private Duty Nursing is only covered in the Home.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Hospice/Bereavement	Indemnity[3]
Hospice *Respite Care is Covered.* *Within 14 days of discharge from a minimum 3 day inpatient stay.* *Hospice limits are combined.* *Limit combined with Skilled Nursing Facility*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 365 Days Per Lifetime
Bereavement Counseling *Respite Care is Covered.*	**Not Covered**

Injections	Indemnity[3]
Injections Outpatient Professional *Includes Administration charge* *See Addendum for special instructions.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Injections	Indemnity[3]
Injections Office Professional *Includes Administration charge* *See Addendum for special instructions.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Inpatient Care - Institutional	Indemnity[3]
Inpatient Accommodations and Ancillaries *Accidental Injury* *General Illness* *Inpatient Surgery* *Maternity* *Newborn Care* *Sick Newborn*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Inpatient Physical Medical Rehab	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Skilled Nursing Facility *Within 14 days of discharge from a minimum 3 day inpatient stay.* *Limit combined with Hospice.*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : 365 Days Per Lifetime

Medical While Hospitalized (Inpatient professional services)	Indemnity[3]
Inpatient Professional Medical Care *General Medical Care* *Consultation, Second Opinion* *Intensive Care, Monitoring* *Newborn Care (Note: for well newborn, no separate deductible and/or co-pay is applied.)* *The charge is applied to the mother's claims only.* *Includes newborn vision/hearing screening when rendered in an inpatient setting.*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A

Alcohol/Substance Abuse	Indemnity[3]
Alcohol/Substance Abuse - Inpatient Institutional *Inpatient Accommodations and Ancillaries* *Includes Detox* *Methadone Clinics are not covered*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Alcohol/Substance Abuse - Residential Treatment Centers - Inpatient *Inpatient Accommodations and Ancillaries* *Includes Detox* *Methadone Clinics are not covered*	**Not Covered**
Alcohol/Substance Abuse - Outpatient Institutional *Methadone Clinics are not covered*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Alcohol/Substance Abuse	Indemnity[3]
Alcohol/Substance Abuse - Intensive Outpatient Therapy (IOP) Institutional *Methadone Clinics are not covered*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Alcohol/Substance Abuse - Partial Hospitalization (PHP) Institutional *Methadone Clinics are not covered*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Alcohol/Substance Abuse - Inpatient Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Alcohol/Substance Abuse - Outpatient Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Mental Health	Indemnity[3]
Mental Health - Inpatient Institutional *Inpatient Accommodations and Ancillaries* *Eating disorders are not covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Mental Health - Residential Treatment Centers - Inpatient *Inpatient Accommodations and Ancillaries* *Eating disorders are not covered.*	**Not Covered**
Mental Health - Outpatient Institutional *Eating disorders are not covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Mental Health - Intensive Outpatient Therapy (IOP) Institutional *Eating disorders are not covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Mental Health - Partial Hospitalization (PHP) Institutional *Eating disorders are not covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Mental Health	Indemnity[3]
Mental Health - Inpatient Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Mental Health - Outpatient Professional *Eating disorders are not covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Mental Health - Office Professional *Eating disorders are not covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Nutritional Counseling - (Non Diabetic)	Indemnity[3]
Nutritional Counseling Outpatient Institutional *Diabetic and Non- Diabetic Nutritional Counseling is covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Nutritional Counseling Outpatient Professional *Diabetic and Non- Diabetic Nutritional Counseling is covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Nutritional Counseling Office Professional *Diabetic and Non- Diabetic Nutritional Counseling is covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Obstetrics, Family Planning, Sterilization	Indemnity[3]
Contraceptives - Covered under Women's Health Provision *Contraceptive Methods - devices (e.g. IUD or diaphragms), injections, implant insertion/removal, the morning after pill and condoms; Sterilization - tubal ligation and vasectomy (excludes birth control pills/patches, abortifacients and spermicide)* *For information on prescription drug coverage for birth control pills/patches, abortifacients, spermicide, the morning after pill and condoms, please see your prescription drug benefits.*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Maternity Care Outpatient Professional *Includes Therapeutic Abortion; Elective Abortion is not covered.* *Dependent Daughters are not covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Obstetrics, Family Planning, Sterilization	Indemnity[3]
Maternity Care Office Professional Visit *Includes Therapeutic Abortion; Elective Abortion is not covered.* *Dependent Daughters are not covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Infertility Services	**Not Covered**
Infertility Treatment - Artificial Insemination	**Not Covered**
Infertility Treatment - Invitro Fertilization *Includes Invitro, GIFT, and ZIFT.*	**Not Covered**
Sterilization - services that do not meet Women's Health Provision requirements *Reversals are Not Covered.* *Vasectomies are covered in full for INN.*	**Not Covered**

Outpatient Hospital Services	Indemnity[3]
Outpatient (Clinic) Institutional	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Outpatient Medical Institutional *Includes Maternity* *If Emergency room-refer to ER benefit.* *Dependent Daughters are NOT covered for Maternity.*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A

Professional Physician Services	Indemnity[3]
Consultation, Second Opinion Outpatient Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Consultation, Second Opinion Office Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Home Visits	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Professional Physician Services	Indemnity[3]
Office Visits Outpatient Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Office Visits Office Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Retail Health Clinics	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Online Visits (Telehealth)	Indemnity[3]
LiveHealth Online	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
LiveHealth Online - Mental Health	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
K Chat *Medical Chats – within Sydney Mobile App.*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Online Visits (Telehealth)	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Online Visits (Telehealth) - Mental Health	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Online Visits (Telehealth)	Indemnity[3]
Telephonic Visits	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Telephonic Visits - Mental Health	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Prescription Drugs under Medical	Indemnity[3]
Prescription Drugs *See Addendum for special instructions.*	**Carved Out**

PREVENTIVE CARE BENEFITS	Indemnity[3]
Exam - Routine Adult physical *Other routine exams are not covered*	**Not Covered**
Well Woman Exam	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A
Exam - Well Child Care *The dollar limit applies to the following routine child care benefits: office visit; laboratory and xray; immunizations and flu/pneumonia injections.*	**Covered - Age Based Cost Share** **Level 1** Covered At : 100% Deductible : No Copayment : N/A Limit : $500 Per Year Rollover Level - Age Limit : 1 Years **Level 2** Covered At : 100% Deductible : No Copayment : N/A Limit : $150 Per Year Age Limit : 9 Years
Immunizations - child and adult (routine) *Travel Immunizations are not covered.* *Routine Child through age 8.Immunizations are covered based on the recommendations by the Department of Health and Human Services - Centers for Disease Control and Prevention* *Routine Child Care for HPV (Gardisil) is not covered.* *Children age 9 - Adult Immunizations are not covered with the exception of Shingles (Zoster) vaccine for an adult age 18 and over.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

PREVENTIVE CARE BENEFITS	Indemnity[3]
Diagnostic X-rays and Lab tests (routine) *Routine Child Labs, X-Rays, Vision & Hearing Screening is covered (birth - age 9)* *Includes routine hearing and vision screenings through age 18. NOT covered for ages 18 and up.* *Routine Adult Labs & X-Rays are covered (age 18 and over)*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Prostate Cancer Screening - PSA (routine)	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Colon cancer screenings (routine) *Routine Fecal Occult Blood Test* *Routine Barium Enema* *Routine Sigmoidoscopy or Colonoscopy* *Facility and anesthesia billed for routine Sigmoidoscopy/Colonoscopy are covered at the same level as the routine Sigmoidoscopy/Colonoscopy.*	**Not Covered**
Vision exam (routine)	**Not Covered**
Hearing exam (routine) *Hearing Tests are not covered.*	**Not Covered**
Pap smear (routine)	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Mammography (routine)	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : 1 Visits Per Year

Surgery Benefits	Indemnity[3]
Assistant Surgeon Inpatient Professional *Covered if medically necessary*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Assistant Surgeon Outpatient Professional *Covered if medically necessary*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Assistant Surgeon Office Professional *Covered if medically necessary*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Surgery Benefits	Indemnity[3]
Oral Surgery *Includes removal of impacted teeth.* *Dental Anesthesia is covered only if related to a payable oral surgery.*	**Covered - At the Surgical Level** Limit : N/A
Surgery Outpatient Institutional	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Surgery Inpatient Professional *Cosmetic/Reconstructive Surgery (subject to medical necessity)*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Surgery Outpatient Professional	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A
Surgery Office Professional	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A

Therapies	Indemnity[3]
Cardiac Rehab Outpatient Institutional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Cardiac Rehab Outpatient Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Cardiac Rehab Office Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Chemotherapy Outpatient Institutional	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A

Therapies	Indemnity[3]
Chemotherapy Inpatient Professional	Covered Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A
Chemotherapy Outpatient Professional	Covered Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Dialysis/Hemodialysis Therapy Outpatient Institutional	Covered Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Dialysis/Hemodialysis Therapy Inpatient Professional	Covered Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A
Dialysis/Hemodialysis Therapy Outpatient Professional	Covered Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Dialysis/Hemodialysis Therapy Office Professional	Covered Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Infusion Therapy Outpatient Institutional	Covered Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Infusion Therapy Inpatient Professional	Covered Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A

Therapies	Indemnity[3]
Infusion Therapy Outpatient Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Infusion Therapy Office Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Occupational Therapy Outpatient Institutional *Limit combined Institutional/Professional.* *Limit combined with Physical, Occupational and Speech Therapy.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 60 Visits Per Year
Occupational Therapy Inpatient Professional	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A
Occupational Therapy Outpatient Professional *Limit combined Institutional/Professional.* *Limit combined with Physical, Occupational and Speech Therapy.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 60 Visits Per Year
Occupational Therapy Office Professional *Limit combined Institutional/Professional.* *Limit combined with Physical, Occupational and Speech Therapy.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 60 Visits Per Year
Physical Therapy Outpatient Institutional *Limit combined Institutional/Professional.* *Limit combined with Physical, Occupational and Speech Therapy.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 60 Visits Per Year
Physical Therapy Inpatient Professional	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A

Therapies	Indemnity[3]
Physical Therapy Outpatient Professional *Limit combined Institutional/Professional.* *Limit combined with Physical, Occupational and Speech Therapy.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 60 Visits Per Year
Physical Therapy Office Professional *Limit combined Institutional/Professional.* *Limit combined with Physical, Occupational and Speech Therapy.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 60 Visits Per Year
Radiation Therapy Outpatient Institutional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Radiation Therapy Inpatient Professional	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A
Radiation Therapy Outpatient Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Radiation Therapy Office Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Respiratory Therapy Outpatient Institutional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Respiratory Therapy Inpatient Professional	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A

Therapies	Indemnity[3]
Respiratory Therapy Outpatient Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Respiratory Therapy Office Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Speech Therapy Outpatient Institutional *Limit combined Institutional/Professional.* *Limit combined with Physical, Occupational and Speech Therapy.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 60 Visits Per Year
Speech Therapy Inpatient Professional	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A
Speech Therapy Outpatient Professional *Limit combined Institutional/Professional.* *Limit combined with Physical, Occupational and Speech Therapy.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : 60 Visits Per Year

TMJ	Indemnity[3]
TMJ Treatment *Covered for medical treatment (surgical and non-surgical).* *Appliances Not Covered.*	**Not Covered**

Transplants Benefits - (Non-BDCT Facility)	Indemnity[1,2,3]
Live Donor Health Services *Donor benefits are limited to benefits not available to the donor from any other source. Medically necessary charges for the procurement of an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Bone Marrow Donor Search Fee *See below for Bone Marrow donor search fee limits.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : $35,000 Per Transplant

Transplants Benefits - (Non-BDCT Facility)	Indemnity[1,2,3]
Organ Transplants (Institutional) *Donor expenses are covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Organ Transplants (Professional) *Donor expenses are covered.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Travel and Lodging for Organ Transplants *See below Travel and Lodging documents for items covered and benefit limits.*	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A

Transplants - (BDCT Facility)	Indemnity[1,2,3]
Live Donor Health Services *Donor benefits are limited to benefits not available to the donor from any other source. Medically necessary charges for the procurement of an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.*	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A
Bone Marrow Donor Search Fee *See below for Bone Marrow donor search fee limits.*	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : $35,000 Per Transplant
Organ Transplants (Institutional) *Donor expenses are covered.*	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A
Organ Transplants (Professional) *Donor expenses are covered.*	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A
Travel and Lodging for Organ Transplants *See below Travel and Lodging documents for items covered and benefit limits.*	**Covered** Covered At : 100% Deductible : Yes Copayment : N/A Limit : N/A

Urgent Care	Indemnity[3]
Urgent Care Outpatient Institutional *When Applicable Prudent Layperson guidelines apply (accidental injury and medical emergency diagnoses pay as emergency).*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Urgent Care Outpatient Professional *When Applicable Prudent Layperson guidelines apply (accidental injury and medical emergency diagnoses pay as emergency).*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A
Urgent Care Office Professional *When Applicable Prudent Layperson guidelines apply (accidental injury and medical emergency diagnoses pay as emergency).*	**Covered** Covered At : 100% Deductible : No Copayment : N/A Limit : N/A

Vision	Indemnity[3]
Vision Exam (non-routine) Outpatient Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Vision Exam (non-routine) Office Professional	**Covered** Covered At : 80% Deductible : Yes Copayment : N/A Limit : N/A
Vision Therapy Outpatient Professional *Sydney K. Chat*	**Not Covered**
Vision Therapy Office Professional *Sydney K. Chat*	**Not Covered**

Notes
1.Prior Authorization by our Medical Management program is required
2.Behavioral Health/Substance Abuse services are administered by Anthem Behavioral Health. Prior Authorization is required for inpatient care
3.Anthem's Medical Management Program must be notified no later than 2 business days in the event of an emergency admission.

Transplant Travel & Lodging Guidelines	
Meals - Restaurants & Take Out: Meals and snacks	Not Covered
Meals - Groceries: Food & beverage (excluding alcohol)	Not Covered
Lodging - Hotel	Covered
Lodging - Motel	Covered
Lodging - Apartment rental	Covered
Travel - Air, Train & Bus fares	Covered

Transplant Travel & Lodging Guidelines	
Travel - Car rental	Covered
Travel - Gas	Covered
Travel - Parking (excluding valet)	Covered
Travel - Tolls	Covered
Travel - Mileage: Car Rental – as long as charged by car rental agency	Covered
Travel - Personal Car mileage – ONLY if the individual does not fly (covered to and from facility)	Covered
Travel - Lodging: valet parking	Not Covered
Miscellaneous - Convenience items: telephone, fax	Not Covered
Miscellaneous - Entertainment items: movies, books, and video rentals	Not Covered
Miscellaneous - Furnishing for apartments: cooking utensils, appliances, furniture	Not Covered
Miscellaneous - Groceries: Alcohol, cigarettes, paper products, toiletries; personal hygiene products	Not Covered
Miscellaneous - Misc.: Laundry service or dry cleaning	Not Covered
Miscellaneous - Gratuities of any kind	Not Covered
Miscellaneous - Laundry detergent	Not Covered
Miscellaneous - Moving trucks (e.g. U-haul)	Not Covered
Miscellaneous - Taxes on covered expenses	Not Covered
Travel includes	Transportation for two companions if the patient is a minor child No dollar limit amount per fare Travel is reimbursed for patient and companion

Bone Marrow Donor Search/Travel and Lodging Benefits Questionnaire	
Transplant approval with the prior carrier be honored	Yes
National Donor Search - National Bone Marrow Donor Search benefit	Yes
National Donor Search - National Bone Marrow Donor Search benefit Maximum	$35,000 Per Transplant
National Donor Search - Benefit can be used at any par PPO facility	Yes
Travel and Lodging Benefit - Travel and Lodging Benefits Applies	Yes
Travel and Lodging Benefit - Travel and Lodging Benefits Maximum	$10,000 Per Transplant
Travel and Lodging Benefit can be used at any par PPO facility	No
Travel and Lodging Benefit only to be used at a Blue Distinction Center for Transplant (BDCT) facility	Yes
Travel and Lodging Benefit - Distance the patient must live from the transplant facility	100 Miles Per Transplant
Lodging Maximum Daily Allowance	$50 Per Day Double Occupancy
Lodging Exclusions - Attach the exclusions	Yes *Alcohol, Cigarettes.* *Personal hygiene products, laundry detergent.*
Travel - One companion traveling with an adult patient covered	Yes
Travel - Two companions traveling with a child patient 18 years old or younger covered	Yes
Travel Exclusions - Attach the exclusions	Yes *Valet Parking* *Personal Car Mileage*

Bone Marrow Donor Search/Travel and Lodging Benefits Questionnaire	
Travel and lodging benefits apply - When patient is going for the initial evaluation	Yes
Travel and lodging benefits apply - When patient is going for follow up care at the transplant facility	Yes
Travel and lodging benefits apply - Patient Referral Contact Name and Number	1-855-690-9129
Travel and lodging benefits apply - Benefits Require Prior Authorization - contact information	1-855-690-9129

Exclusions-Enterprise Non-Standard List

GROUP SPECIFIC EXCLUSIONS

Services: a. Not furnished by a qualified practitioner or qualified treatment facility; b. Not authorized or prescribed by a qualified practitioner; c. Not specifically covered by this Plan whether or not prescribed by a qualified practitioner; d. Which are not provided; e. For which no charge is made, or for which you would not be required to pay if you were not covered under this Plan unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; f. Furnished by or payable under any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid); g. Furnished for a military service connected sickness or bodily injury by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs; h. Performed in association with a service that is not covered under this Plan.

Immunizations required for foreign travel.

Radial keratotomy, refractive keratoplasty or any other surgery to correct myopia, hyperopia or stigmatic error.

Cosmetic surgery and cosmetic services or devices, unless for reconstructive surgery: a. Resulting from a bodily injury, infection or other disease of the involved part, when functional impairment is present; or b. Resulting from a congenital disease or anomaly of a covered dependent child which resulted in a functional impairment. Expense incurred for reconstructive surgery performed due to the presence of a psychological condition is not covered, unless the condition(s) described above are also met.

Hair prosthesis, hair transplants or hair implants.

Dental services or appliances for the treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, implants and related procedures, routine dental extractions and orthodontic procedures, unless specifically provided under this Plan.

Services which are: a. Rendered in connection with a mental health disorder not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation.

Marriage counseling.

Court-ordered mental health or substance abuse services.

Education or training, unless otherwise specified in this Plan.

Educational or vocational therapy, testing, services or schools, including therapeutic boarding schools and other therapeutic environments. Educational or vocational videos, tapes, books and similar materials are also excluded.

Expenses for services that are primarily and customarily used for environmental control or enhancement (whether or not prescribed by a qualified practitioner) and certain medical devices including, but not limited to: a. Common household items including air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows or exercise equipment; b. Motorized transportation equipment (e.g. scooters), escalators, elevators, ramps or modifications or additions to living/working quarters or transportation vehicles; c. Personal hygiene equipment including bath/shower chairs, transfer equipment or supplies or bed side commodes; d. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools, whirlpools, spas or saunas; e. Medical equipment including blood pressure monitoring devices, PUVA lights and stethoscopes; f. Communication system, telephone, television or computer systems and related equipment or similar items or equipment; g. Communication devices, except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

Any medical treatment, procedure, drug, biological product or device which is experimental, investigational or for research purposes, unless otherwise specified in this Plan;

Services that are not medically necessary, except routine/preventive services.

Charges in excess of the maximum allowable fee for the service.

Services provided by a person who ordinarily resides in your home or who is a family member.

Any expense incurred prior to your effective date under this Plan or after the date your coverage under this Plan terminates, except as specifically described in this Plan.

Expenses incurred for which you are entitled to receive benefits under your previous dental or medical plan;

Any expense due to the covered person's: a. Engaging in an illegal occupation; or b. Commission of or an attempt to commit a criminal act.

Any loss caused by or contributed to: a. War or any act of war, whether declared or not; b. Insurrection; or c. Any act of armed conflict, or any conflict involving armed forces of any authority.

Any expense incurred for services received outside of the United States, except for emergency care services, unless otherwise determined by this Plan.

Exclusions-Enterprise Non-Standard List

GROUP SPECIFIC EXCLUSIONS

Treatment of nicotine habit or addiction, including, but not limited to hypnosis, smoking cessation products, classes or tapes, unless otherwise determined by this Plan.

Vitamins, dietary supplements and dietary formulas, except enteral formulas, nutritional supplements or low protein modified food products for the treatment of an inherited metabolic disease, e.g. phenylketonuria (PKU);

Prescription drugs and self-administered injectable drugs , unless administered to you: a. While inpatient in a hospital, qualified treatment facility or skilled nursing facility; or b. By the following, when deemed appropriate by this Plan: a qualified practitioner, during an office visit, while outpatient, or at a home health care agency as part of a covered home health care plan approved by this Plan.

Any drug prescribed, except: a. FDA approved drugs utilized for FDA approved indications; or b. FDA approved drugs utilized for off-label drug indications recognized in at least one compendia reference or peer-reviewed medical literature deemed acceptable to this Plan.

Off-evidence drug indications.

Over-the-counter, non-prescription medications unless for drugs, medicines or medications on the Women's Healthcare Drug List with a prescription from a qualified practitioner. See the Prescription Drug Benefit;

Growth hormones (medications, drugs or hormones to stimulate growth) ;

Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization test and/or treatment UNLESS such therapy or testing is approved by: a. The American Academy of Allergy and Immunology, or b. The Department of Health and Human Services or any of its offices or agencies;

Professional pathology or radiology charges, including but not limited to, blood counts, multichannel testing, and other clinical chemistry tests, when: a. The services do not require a professional interpretation, or b. The qualified practitioner did not provide a specific professional interpretation of the test results of the covered person;

Services that are billed incorrectly or billed separately, but are an integral part of another billed service;

Expenses for health clubs or health spas, aerobic and strength conditioning, work-hardening programs or weight loss or similar programs, and all related material and product for these programs;

Alternative medicine;

Services rendered in a premenstrual syndrome clinic or holistic medicine clinic;.

Services of a midwife, unless provided by a Certified Nurse Midwife

The following types of care of the feet: a. Shock wave therapy of the feet. b. The treatment of weak, strained, flat, unstable or unbalanced feet. c. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis. d. The treatment of tarsalgia, metatarsalgia, or bunion, except surgically. e. The cutting of toenails, except the removal of the nail matrix. f. The provision of heel wedges, lifts or shoe inserts. g. The provision of arch supports or orthopedic shoes. Arch supports and orthopedic shoes are covered if medically necessary because of diabetes or hammertoe;

Custodial care and maintenance care;

Weekend non-emergency hospital admissions, specifically admissions to a hospital on a Friday or Saturday at the convenience of the covered person or his or her qualified practitioner when there is no cause for an emergency admission and the covered person receives no surgery or therapeutic treatment until the following Monday;

Hospital inpatient services when you are in observation status;

Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, registered nurse or certified operating room technician unless medically necessary;

Ambulance services for routine transportation to, from or between medical facilities and/or a qualified practitioner's office;

Preadmission testing/procedural testing duplicated during a hospital confinement;

Lodging accommodations or transportation, unless specifically provided under this Plan;

Communications or travel time;

No benefits will be provided for the following: a. Immunotherapy for recurrent abortion; b. Chemonucleolysis; c. Biliary lithotripsy; d. Home uterine activity monitoring; e. Sleep therapy; f. Light treatments for Seasonal Affective Disorder (S.A.D.); g. Immunotherapy for food allergy; h. Prolotherapy; i. Cranial banding; j. Hyperhidrosis surgery; k. Lactation therapy; or l. Sensory integration therapy;

Exclusions-Enterprise Non-Standard List

GROUP SPECIFIC EXCLUSIONS

Any covered expenses to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments or recovery from any identifiable fund regardless of whether the beneficiary was made whole;

Any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which: a. Benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, or b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased;

Routine physical examinations and related services for occupation, employment, school, sports, camp, travel, purchase of insurance or premarital tests or examinations, unless specifically provided under this Plan;

Surrogate parenting.

Routine vision examinations;

Routine vision refraction;

The purchase, fitting or repair of eyeglass frames and lenses or contact lenses, unless specifically provided under this Plan;

Vision therapy;

Routine hearing examinations;

Routine hearing testing;

Hearing aids, the fitting or repair of hearing aids or advice on their care; implantable hearing devices, except for cochlear implants and auditory brain stem implants as determined by this Plan;

Elective medical or surgical abortion, unless: a. The pregnancy would endanger the life of the mother; or b. The pregnancy is a result of rape or incest; or c. The fetus has been diagnosed with a lethal or otherwise significant abnormality;

Services for a reversal of sterilization;

Birth control pills and patches, devices, injections, implant systems and the removal of implant systems;

Wigs except for cancer patients with hair loss resulting from chemotherapy and/or radiation therapy;

Obesity services;

Morbid obesity services;

Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or weight loss surgery;

Dental osteotomies;

Services for any jaw joint problem including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull and treatment of the facial muscles used in expression and mastication functions, for symptoms including but not limited to, headaches;

Infertility counseling and treatment services;

Artificial means to achieve pregnancy or ovulation, including, but not limited to, artificial insemination, in vitro fertilization, spermatogenesis, gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), tubal ovum transfer, embryo freezing or transfer and sperm banking;

Services related to the treatment and/or diagnosis of sexual dysfunction/impotence;

Acupuncture;

Half-way house services;

Residential treatment facilities.

Gene Replacement Therapy