HEALTH BENEFIT BOOKLET

DIOCESE OF FORT WAYNE – SOUTH BEND, INC.
PPO PACKAGE 001
EFFECTIVE 1/1/ 2016

Administered By

BENEFIT BOOKLET

This Benefit Booklet has been prepared by the Claims Administrator, on behalf of the Employer, to help explain Your health benefits. This document replaces and supersedes any Benefit Booklet or summary that You have received previously.

Please refer to this Benefit Booklet whenever You require health services. It describes how to access medical care, what health services are covered by the Plan, and what portion of the health care costs You will be required to pay.

This Benefit Booklet should be read and re-read in its entirety. Since many of the provisions of this Benefit Booklet are interrelated, You should read the entire Benefit Booklet to get a full understanding of Your health benefits.

Many words used in the Benefit Booklet have special meanings. These words appear in capitals and are defined for You. Refer to these definitions in the Definitions section for the best understanding of what is being stated.

This Health Benefit Booklet also contains Exclusions, so please be sure to read this Health Benefit Booklet carefully.

Verification of Benefits
Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Customer Service with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 8:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. CALL THE CUSTOMER SERVICE NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If You need assistance in Spanish to understand this document, You may request it for free by calling customer service at the number on Your Identification Card.

Administered by
Anthem Insurance Companies, Inc.

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

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MEMBER RIGHTS AND RESPONSIBILITIES

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

You have the right to:

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

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health Plan rules and policies.
- Choose an In-Network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.

- Follow the health care plan that You have agreed on with Your health care Providers.
- Give the Claims Administrator, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with the Plan.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

If You would like more information, have comments, or would like to contact the Claims Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your ID Card.

The Claims Administrator wants to provide high quality customer service to our Members. Benefits and coverage for services given under the Plan are governed by the Employer's Plan and not by this Member Rights and Responsibilities statement.

How to Obtain Language Assistance

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

SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the percentage Coinsurance amounts and other limits when You receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any attachments or riders. **This Schedule of Benefits lists the Member's responsibility for Covered Services and supplies.** Under certain circumstances, if the Claims Administrator pays the healthcare provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

COVERED SERVICES	TIER 1 CATHOLIC DIOCESE DESIGNATED HOSPITALS	TIER 2 ANTHEM BLUE ACCESS PPO	TIER 3 OUT-OF-NETWORK
Benefit Period	Calendar Year		
Dependent Age Limit	To the end of the month in which the child attains age 26.		
Calendar Year Deductible • Per Person • Per Family	None	$500 $1,000	$750 $1,500
All Covered Services are subject to the Deductible unless otherwise specified in this booklet.			
Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.			
Your Plan has an embedded Deductible which means: • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If You also cover Dependents (other family members) under this Plan, both the "Individual" and the "Family" amounts apply. The "Family" Deductible amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Deductible amount before the "Family" amount is met. You will never have to satisfy more than Your own 'Individual" Deductible amount. If You meet Your "Individual" Deductible amount, Your other family member's claims will still accumulate towards their own "Individual" Deductible and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Deductible or the entire "Family" Deductible is met.			

COVERED SERVICES	TIER 1 CATHOLIC DIOCESE DESIGNATED HOSPITALS	TIER 2 ANTHEM BLUE ACCESS PPO	TIER 3 OUT-OF-NETWORK
Amounts satisfied toward the Network calendar year Deductible will be applied toward the Out-of-Network calendar year Deductible and amounts satisfied toward the Out-of-Network calendar year Deductible will be applied toward the Network calendar year Deductible.			
Note: When a Member incurs covered medical expenses during the last 3 months of the Benefit Period, which are applied against but do not satisfy that year's Deductible, those expenses may be carried over and applied against the Deductible(s) for the next Benefit Period, but not the Out-of-Pocket. If the Deductible is met, there is no carry-over credit given.			
Out-of-Pocket Limit • Per Person • Per Family	 $1,000 $2,000	 $1,000 $2,000	 $1,500 $3,000
The Out-of-Pocket includes Coinsurance and the calendar year Deductible. Does NOT include Prescription Drug benefits, Precertification penalties, or charges in excess of the Maximum Allowed Amount or Non-Covered Services.			
Your Plan has an embedded Out-of-Pocket which means: • If You, the Subscriber, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If You also cover Dependents (other family members) under this Plan, both the "Individual" and "Family" amounts apply. The "Family" Out-of-Pocket amounts can be satisfied by any combination of family members but You could satisfy Your own "Individual" Out-of-Pocket amount before the "Family" amount is met. You will never have to satisfy more than Your own 'Individual" Out-of-Pocket amount. If You meet Your "Individual" amount, other family member's claims will still accumulate towards their own "Individual" Out-of-Pocket and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Out-of-Pocket or the entire 'Family" Out-of-Pocket is met.			
Amounts satisfied toward the Network Out-of-Pocket Maximum will be applied toward the Out-of-Network Out-of-Pocket Maximum and amounts satisfied toward the Out-of-Network Out-of-Pocket Maximum will be applied toward the Network Out-of-Pocket Maximum.			

FACILITY COVERAGE TIERS	TIER 1 CATHOLIC DIOCESE DESIGNATED HOSPITALS	TIER 2 ANTHEM BLUE ACCESS PPO	TIER 3 OUT-OF-NETWORK
	• **St Joseph's Med Center of Ft. Wayne** • **St Joseph's Med Center of South Bend** • **St Joseph's Community Hospital of Mishawaka** • **St Joseph's Hospital of Marshall County**		

COVERED SERVICES	TIER 1 CATHOLIC DIOCESE DESIGNATED HOSPITALS	TIER 2 ANTHEM BLUE ACCESS PPO	TIER 3 OUT-OF-NETWORK
Preventive Care - medical History - physical exams- 1 per calendar year - mammograms 1 per calendar year - pelvic exams - PAP testing - Pap Smear 1 per calendar year - Prostate Testing 1 per calendar year - Colorectal exam 1 per calendar year - bone density 1 per calendar year - immunizations Eligible Well Child Care - 6 exams up to age 2 Hearing & vision is NOT covered.	First $250 Covered in Full, then Deductible and 10% Coinsurance	First $250 Covered in Full, then Deductible and 20% Coinsurance	First $250 Covered in Full, then Deductible and 30% Coinsurance

COVERED SERVICES	TIER 1 CATHOLIC DIOCESE DESIGNATED HOSPITALS	TIER 2 ANTHEM BLUE ACCESS PPO	TIER 3 OUT-OF- NETWORK
Physician Office Services • office visits • office surgeries • Natural Family Planning • allergy - testing and treatment - serum and injections(1)	N/A	20% Coinsurance	30% Coinsurance
Outpatient Services (Network & Non-Network Limits Apply) • Physical and Occupational therapy: unlimited visit limit • Speech therapy: unlimited visit limit • Spinal Manipulation: unlimited visit limit	10% Coinsurance	20% Coinsurance	30% Coinsurance
Inpatient Services unlimited days for Physical Medicine / Rehabilitation	10% Coinsurance	20% Coinsurance	30% Coinsurance
Outpatient Facility Services	10% Coinsurance	20% Coinsurance	30% Coinsurance
Inpatient and Outpatient Professional and Ancillary Charges • Inpatient • Outpatient physician services	10% Coinsurance	20% Coinsurance	30% Coinsurance
Diagnostic Services (Office/Independent Lab)	Covered in Full	Covered in Full	30% Coinsurance

COVERED SERVICES	TIER 1 CATHOLIC DIOCESE DESIGNATED HOSPITALS	TIER 2 ANTHEM BLUE ACCESS PPO	TIER 3 OUT-OF- NETWORK
Diagnostic Services (Outpatient)	10% Coinsurance	20% Coinsurance	30% Coinsurance
Temporomandibular Joint (TMJ) Services	10% Coinsurance	20% Coinsurance	30% Coinsurance
Home Care Services	10% Coinsurance	20% Coinsurance	30% Coinsurance
Hospice Services	Covered in Full	Covered in Full	Covered in Full
Bereavement Counseling 15 visits per any 6-month period 15 visit lifetime maximum limit	50% Coinsurance	50% Coinsurance	50% Coinsurance
Emergency Care Hospital Emergency Room: • physician services • facility charges	10% Coinsurance	10% Coinsurance	10% Coinsurance
Urgent Care Facility: • physician services • facility charges	10% Coinsurance	20% Coinsurance	30% Coinsurance
Ambulance Services	10% Coinsurance	20% Coinsurance	30% Coinsurance
Maternity Services			
Inpatient / Outpatient Services	10% Coinsurance	20% Coinsurance	30% Coinsurance
Physician Office Services	N/A	20% Coinsurance (Global fees apply. No charges after 1st prenatal visit)	30% Coinsurance (Global fees apply. No charges after 1st prenatal visit)

COVERED SERVICES	TIER 1 CATHOLIC DIOCESE DESIGNATED HOSPITALS	TIER 2 ANTHEM BLUE ACCESS PPO	TIER 3 OUT-OF- NETWORK
Mental Health			
Inpatient care	10% Coinsurance	10% Coinsurance	30% Coinsurance
Outpatient care	10% Coinsurance	20% Coinsurance	30% Coinsurance
Professional Office Visits	N/A	20% Coinsurance	30% Coinsurance
Note: Services include ADD, ADHD, developmental delays, autistic disease, learning disabilities, hyperkinetic syndromes, and mental retardation.			
Substance Abuse			
Inpatient care	10% Coinsurance	10% Coinsurance	30% Coinsurance
Outpatient care	10% Coinsurance	20% Coinsurance	30% Coinsurance
Professional Office Visits	N/A	20% Coinsurance	30% Coinsurance
Coverage for the treatment of Behavioral Health and Substance Abuse Services is provided in compliance with federal law.			
Medical Supplies, Equipment, and Appliances Rental cost up to the purchase price	10% Coinsurance	20% Coinsurance	30% Coinsurance
Nutritional Counseling for Non-Diabetics	Covered at the benefit level of the services billed.		
Nutritional Counseling for Eating Disorders	Covered at the benefit level of the services billed.		
NOTE: Due to network availability in some states, Out-of-Network Providers will be paid at the In Network level. Coverage includes but is not limited to TMJ appliances and blood glucose monitors.			

COVERED SERVICES	TIER 1 CATHOLIC DIOCESE DESIGNATED HOSPITALS	TIER 2 ANTHEM BLUE ACCESS PPO	TIER 3 OUT-OF-NETWORK
Human Organ and Tissue Transplant Services			
Tissue Transplants • Inpatient services • Outpatient facility services • Physician Facility services	Covered in Full	Covered in Full	50% Coinsurance
For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services, or Physician Office Services depending where the service is performed.			
Benefit Period	Total of 365 continuous days beginning 1 day immediately prior to a Covered Transplant Procedure or first myeloblation therapy (high dose chemotherapy and/or irradiation).		
Non-Network Transplant Facility Transplant Services provided through a Non-Network Transplant Facility, with respect to the type of Covered Transplant Procedure performed: If the Covered Transplant Procedure is performed in a Non-Network Transplant Facility, You will pay the lesser of 50% of billed charges, or 50% of the Maximum Allowable Amount.			

COVERED SERVICES	TIER 1 CATHOLIC DIOCESE DESIGNATED HOSPITALS	TIER 2 ANTHEM BLUE ACCESS PPO	TIER 3 OUT-OF- NETWORK
Transplant Services and Procedures With respect to the type of Covered Transplant Procedure performed:	Covered in Full	Covered in Full	The lesser of 50% of billed charges, or, 50% of the Maximum Allowable Amount. If the Provider is also a Network Provider for this Plan (for services other than Transplant Services and Procedures), then You will **not** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. If the Provider is a Non-Network Provider for this Plan, You **will** be responsible for Covered Services, which exceed the Plan's Maximum Allowable Amount.
COVERED SERVICES	**TIER 1 CATHOLIC DIOCESE DESIGNATED HOSPITALS**	**TIER 2 ANTHEM BLUE ACCESS PPO**	**TIER 3 OUT-OF- NETWORK**
Transportation and Lodgings	10% Coinsurance	20% Coinsurance	30% Coinsurance
Reasonable and necessary travel expenses related to a transplant at a Non-Network Transplant Facility are covered at the Non-Network Transplant Facility benefit level.			

NOTES: Visit limits are applied per benefit period, except where otherwise stated.

DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Administrative Services Agreement - The agreement between the Claims Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan. This Benefit Booklet in conjunction with the Administrative Services Agreement, the application, if any, any amendment or rider, Your Identification Card and Your application for enrollment constitutes the entire Plan. If there is any conflict between either this Benefit Booklet or the Administrative Services Agreement and any amendment or rider, the amendment or rider shall control. If there is any conflict between this Benefit Booklet and the Administrative Services Agreement, the Administrative Services Agreement shall control.

Alternate Recipient - Any child of a Subscriber who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under the Plan with regard to such Subscriber.

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

Behavioral Health Care - Includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Benefit Booklet - This summary of the terms of Your health benefits.

Benefit Period - The period of time that benefits for Covered Services are payable under the Plan. The Benefit Period is listed in the Schedule of Benefits. If Your coverage ends earlier, the Benefit Period ends at the same time.

Claims Administrator - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Claims Administrator is Anthem Insurance Companies, Inc. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services that is indicated in the Schedule of Benefits, which You must pay. Coinsurance normally applies to the Out-of-Pocket Limit that You are required to pay. See the Schedule of Benefits for any exceptions.

Covered Services - Services, supplies, or treatment as described in this Benefit Booklet, which are performed, prescribed, directed, or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Benefit Booklet.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under the Plan is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Benefit Booklet, or by any amendment or rider thereto.
- Authorized in advance by the Claims Administrator, on behalf of the Employer, if such Prior Authorization is required in the Plan.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to You.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by the Claims Administrator, on behalf of the Employer, including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Custodial Care - Care primarily for the purpose of assisting You in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;

- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and

preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Deductible - The dollar amount of Covered Services listed in the Schedule of Benefits for which You are responsible before benefits are payable under the Plan for Covered Services each Benefit Period.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Plan.

Diagnostic Service - A test or procedure performed when You have specific symptoms to detect or to monitor Your disease or condition or a test performed as a Medically Necessary preventive care screening for an asymptomatic patient. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date Your coverage begins under the Plan. You must be Actively at Work on Your Effective Date. If You are not Actively at Work on Your Effective Date, Your Effective Date will be the date You become Actively at Work. A Dependent's coverage under the Plan begins on the Effective Date of the sponsoring Subscriber. No benefits are payable for services and supplies received before Your Effective Date or after Your termination date.

Eligible Person - A person who satisfies the Employer's eligibility requirements and is entitled to apply to be a Subscriber.

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

- place an individual's health in serious jeopardy;

- result in serious impairment to the individual's bodily functions; or

- result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care - Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

Employer – The legal entity contracting with the Claims Administrator for administration of group health care benefits.

Enrollment Date - The first day of coverage under the Plan or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

Experimental/Investigative - Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which the Claims Administrator determines to be unproven.

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

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

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

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

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

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

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

Family Coverage – Coverage provided by the Employer for the Subscriber and eligible Dependents.

Fee(s) - The periodic charges which are required to be paid by You and/or the Employer to maintain benefits under the Plan.

Identification Card - A card issued by the Claims Administrator, on behalf of the Employer, that bears the Member's name, identifies the membership by number, and may contain information about Your benefits under the Plan. It is important to carry this card with You.

Inpatient - A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Late Enrollee - An individual whose enrollment under the Plan is a Late Enrollment.

Late Enrollment - Enrollment other than on:

- The earliest date on which benefits can become effective under the Plan; or

- The date of an event that qualifies for Special Enrollment.

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

Medically Necessary or **Medical Necessity** - An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by the Claims Administrator to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- 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;
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Benefit Booklet.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and **does not** guarantee payment.

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member - A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Employer and for whom Fee payment has been made. Members are sometimes called "You" or "Your."

Natural Family Planning - Covered Services shall include instruction and individual follow-up in any method of natural fertility regulation provided by a certified instructor or provider group, including necessary materials.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by the Claims Administrator, or with another organization, which has an agreement with the Claims Administrator, regarding payment for Covered Services and certain administration functions for the Network associated with the Plan.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by the Claims Administrator, on behalf of the Employer, or with another organization, which has an agreement with the Claims Administrator, on behalf of the Employer, to provide Covered Services and certain administrative functions to You for the network associated with this Benefit Booklet. A Hospital may be a Network Transplant Facility with respect to:

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

New FDA Approved Drug Product or Technology - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced Generic medication (Generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider - A Provider who has not entered into a contractual agreement with Claims Administrator, on behalf of the Employer, or is not otherwise engaged by Claims Administrator, on behalf of the Employer, for the network associated with this Plan. Providers who have not contracted or affiliated with Claims Administrator's designated Subcontractor(s)

for the services they perform under this Plan are also considered Non-Participating/Network Providers.

Non-Network Transplant Facility - Any Hospital, which has not contracted with the transplant network engaged by Claims Administrator, on behalf of the Employer, to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or

- All Covered Transplant Procedures.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a Benefit Period as listed in the Schedule of Benefits. Such expense does not include charges in excess of the Maximum Allowable Amount or any non-Covered Services. Refer to the Schedule of Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional percentage Coinsurance amounts are required unless otherwise specified in this Benefit Booklet.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Plan – The group health benefit Plan provided by the Employer and explained in this Benefit Booklet.

Private Duty Nursing Services

Private Duty Nursing (PDN) Services include only Skilled Nursing Services ordered by a Physician and rendered in the home or as an Inpatient by a practicing Registered Nurse (R.N) or Licensed Practical Nurse (L.P.N.). Skilled Nursing Services do not include Custodial Care or services which could be performed by the average non-medical person with proper training even if ordered by Physician. (See the definitions of Skilled Nursing Services and Custodial Care for examples of care which are not covered.) PDN Services are limited to the amount shown in the Schedule of Benefits.

Provider - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question if a Provider is covered, please call the number on the back of Your ID card. Providers include, but are not limited to, the following persons and facilities:

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

    1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);

2. Surgery;

3. Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A Provider that:

1. is licensed as such, where required;

2. is equipped mainly to do Surgery;

3. has the services of a Physician and a Registered Nurse (R.N.) at all times when a patient is present;

4. is not an office maintained by a Physician for the general practice of medicine or dentistry; and is equipped and ready to initiate Emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:

1. constituted, licensed, and operated as set forth in the laws that apply;

2. equipped to provide low-risk maternity care;

3. adequately staffed with qualified personnel who:

a. provides care at childbirth;

b. are practicing within the scope of their training and experience; and

c. are licensed if required; and

4. equipped and ready to initiate Emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the

medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. 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:

  1. nursing care;

  2. rest care;

  3. convalescent care;

  4. care of the aged;

  5. Custodial Care;

  6. educational care;

  7. treatment of alcohol abuse; or

  8. treatment of drug abuse.

- **Physician -**

  1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

  2. any other legally licensed practitioner of the healing arts rendering services which are:

     a. covered by the Plan;

     b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

  1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

  2. provides care supervised by a Physician;

  3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

  4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

  5. is not a rest, educational, or custodial Provider or similar place.

- **Urgent Care Center -** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

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

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

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

Recovery – A Recovery is money You receive from another, their insurer or from any "Uninsured Motorist," "Underinsured Motorist," "Medical-Payments," "No-Fault," or "Personal Injury Protection," or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how You or Your representative or any agreements characterize the

money You receive, it shall be subject to the Subrogation and Reimbursement provisions of this Benefit Booklet.

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

Service Area - The geographical area within which Covered Services under the Plan are available.

Single Coverage – Coverage for the Subscriber only.

Skilled Care - Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

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

Stabilize - The provision of medical treatment to You in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of Your condition is not likely to result from or during any of the following:

- Your discharge from an Emergency department or other care setting where Emergency Care is provided to You;

- Your transfer from an Emergency department or other care setting to another facility; or

- Your transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor - The Claims Administrator and/or Employer may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Claims Administrator or Employer's behalf.

Subscriber - An eligible employee or retired employee or Member of the Employer enrolled under the Plan, whose benefits are in effect and whose name appears on the Identification Card issued by the Claims Administrator, on behalf of the Employer.

Temporomandibular or Craniomandibular Joint disorder (TMJ) - Temporomandibular joint is a complicated joint formed where the lower jawbone attaches to the head. TMD refers to general class of disorder affecting the bones and muscles of this region. Symptoms range from tenderness and swelling to headaches and neck and back aches. Generally, a clicking or popping sound when the jaw is opened or closed is evidence or some form of one of the disorders.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Transplant Providers

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

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

Out-of-Network Transplant Provider - Any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by a designee of the Claims Administrator.

Utilization Review - A function performed by the Claims Administrator or by an organization or entity selected by the Claims Administrator to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, Outpatient care or diagnostic services are appropriate.

ELIGIBILITY, ENROLLMENT, TERMINATION, CONTINUATION AND CONVERSION

Eligibility for Benefit

(1) Employee Eligibility – Each Employee is eligible to enroll provided such Employee meets all of the following Requirements:

a. is in an eligible class as shown below:

(i.) all active, full-time Employees defined as follows:

All Diocesan and other priests who are under assignment and approved by the Bishop of the Diocese in this Diocese, all Diocesan priests who are retired from this Diocese and any other priests and Seminarians who may be approved by the Bishop of the Diocese;

Any religious sisters or brothers who are under assignment in the Diocese with the approval of the Bishop of the Diocese;

Lay Employees (Non Teaching) who consistently maintain active employment of at least 30 hours per week;

Lay Employee (Elementary School Teacher) – a person who is contracted to teach 30 or more hours per week for a consecutive period equivalent to at least one full semester during the school year; or

Lay Employee (High School Teacher) – a person who is contracted to teach an average of five classroom periods of recitation and assumes daily supervisory assignments for a consecutive period equivalent to at least one full semester during the school year.

b. has completed a service requirement referred to as a Waiting Period:

(i.) the first day of the month following full-time employment;

c. has completed an enrollment application.

Failure of the Employee to enroll in the 30 days following the end of the Waiting Period will cause the Employee to be a Late Enrollee at the time of future enrollment unless the Employee qualifies for Special Enrollment.

(2) Dependent Eligibility – Each Employee that is enrolled can enroll Dependents under the Plan on the later of the following:

a. for initially eligible Dependents, the date of the Employee is eligible to enroll; or

b. for newly acquired Dependents, the date the Dependent is first acquired by the Employee if the Employee is enrolled on that date.

Failure to enroll initially eligible Dependents in the 30 days following the end of the Employee Waiting Period will cause the Dependents to be Late Enrollees at the time of future enrollment unless the Dependent qualifies for Special Enrollment.

The event of acquiring a new Dependent means marriage, birth, adoption, placement for adoption or satisfying any other definitions of Dependency as described in this Plan.

The election to enroll a newly acquired Dependent can occur at any time not more than 30 days following the event of acquiring the Dependent. If the Employee has dependent coverage under this Plan and such Employee or spouse of the Employee gives birth, the newborn Dependent shall be enrolled in the Plan automatically as of the date of birth. Any other newly acquired Dependent must be enrolled in accordance with the terms of the Plan. Failure to enroll a newly acquired Dependent in the 30 days following the acquisition event will cause such Dependent to be a late Enrollee at the time of future enrollment unless the Dependent qualifies for Special Enrollment.

No person is eligible for coverage as an Employee and as a Dependent. If both parents of a child are covered Employees under the Plan, the child may be covered as a Dependent of only one parent.

(3) Dependents eligible to participate include:

a. coverage will be extended only to the opposite sex Spouse of the Employee. For information on spousal eligibility please contact the Employer;

b. a natural child, a step child, a legally adopted child, a child placed for adoption, a child who has been placed under the legal guardianship of the Employee or a child for whom the Employee has financial responsibility for medical Expense as the result of a legal decree. To be eligible, a child also must meet all of the following conditions:

(i) dependent children until at the end of the month they attain age 26

NOTE: Under any circumstance, a Dependent child covered under the predecessor plan on the day prior to the effective date of this Plan shall be covered by this Plan as long as such child continues to satisfy criteria (i) of this Section (3) b.

The limiting age of 26 does not apply to an enrolled child who is mentally or physically handicapped at or prior to the time the child reaches the limiting age. Upon attaining the limiting age, the child must also be incapable of self-sustaining employment and chiefly dependent upon the Employee for support and maintenance. Proof of incapacity must be furnished to the Employer; additional proof may be requested from time to time.

ADOPTED CHILDREN: The Plan allows coverage of a child who has been adopted or placed for adoption. Placement for adoption means the assumption and retention by a Plan Participant of a legal obligation for total or partial support of such child in anticipation of such adoption.

Qualified Medical Child Support Order

(1) A Qualified Medical Child Support Order (QMCSO) is a court judgment or decree that requires the Plan to offer coverage to the child of a Participant, referred to as an alternate recipient.

(2) The medical child support order must meet four requirements to be deemed as qualified:

a. disclose the name and last known mailing address of the Participant and each alternate recipient;
b. reasonably describe the type of benefits or coverage to be provided by the Plan;
c. define the period of time to which the order applies; and
d. identify each Plan to which the order applies.

(3) The QMCSO cannot require the Plan to provide benefits not included under the Plan.

(4) Coverage of an alternate recipient is subject to all provisions of the Plan including, but not limited to, timely payment of required contributions, enrollment procedures and limitations of coverage.

(5) The Plan Administrator has established procedures for determining if a court judgment or decree is a QMCSO. A Participant can obtain a copy of these procedures without cost upon written request to the Plan Administrator.

Application For Participation

(1) Each Employee must apply for Plan participation on such forms or electronic format as the Employer shall provide and shall agree to the terms of the Plan. The Employer shall determine Participant eligibility based upon information supplied.

(2) The enrollment application shall include a statement which, upon signature or acceptance by the Employee, authorizes the Employer to make payroll withholding of any required contribution by the Employee for the cost of benefits. Such authorization is part of the application procedure.

(3) If a declination to enroll occurs due to other coverage of an Employee or Dependent, the Employee must state in writing that the reason for declination is due to other coverage. Failure to make the written statement will void the right to Special Enrollment at a future date.

(4) The Participant is solely responsible for the accuracy of information and to notify the Plan Administrator of any change in status that may have a material effect on eligibility or otherwise affect the capability of the Plan Administrator to fulfill the obligations of the Plan.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Effective Date of Coverage

(1) If completion of the enrollment application occurs prior to or during the 30 days immediately following the scheduled effective date, coverage begins on the scheduled effective date.

(2) The scheduled effective date is the first day of the month coincident with or next following the end of the service Waiting Period. The service Waiting Period begins on the first day of Actively At Work, full-time employment.

(3) If an Employee is not Actively at Work on the scheduled effective date except for health related causes and the effective date is a regularly scheduled work day, neither Employee nor Dependent coverage begins until the day the Employee returns to active, full-time employment.

(4) If the scheduled effective date falls on a non-work or vacation day, coverage begins on the scheduled effective date if the Employee was Actively at Work on the last preceding regularly scheduled work day or, if absent from work; such absence was due to health related causes. Otherwise, neither Employee nor Dependent coverage begins until the day the Employee returns to active, full-time employment.

(5) Application for coverage at any other time that does not qualify as a Special Enrollment shall constitute late application and the person is subject to Late Enrollee provisions.

(6) For a Late Enrollee, the effective date of coverage is the date of enrollment.

(7) Upon completion of application requirements, the effective date of coverage for Dependents is described as follows:

a. for initially eligible Dependents, the date the Employee is effective;

b. for newly acquired Dependents, the date a Dependent is first acquired by the Employee if the Employee is covered on that date; or

c. for a Late Enrollee, the effective date of coverage is the date of enrollment.

(8) A terminated Employee, whose coverage has terminated, may reapply for coverage within twelve (12) months following such termination of employment without fulfilling the Waiting Period requirement.

Late Enrollee

A person who enrolls at a time other than when first eligible, except for a Special Enrollment or Dependent Special Enrollment event, is a Late Enrollee. A Late Enrollee is not subject to the Waiting Period.

For a Late Enrollee, the effective date of coverage is the date of enrollment.

Special Enrollment

(1) A Special Enrollment right exists for eligible Employees and Dependents who previously declined coverage under this Plan due to having other health coverage and subsequently loses such other coverage. To qualify for Special Enrollment, the Employee must:

a. state in writing at the time of initial eligibility that declination of coverage under this Plan was due to having other coverage;

b. make the request for Special Enrollment; and

c. complete any required Enrollment Forms under this Plan not more than 30 days following the loss of other coverage.

(2) A person who enrolls under the provisions for Special Enrollment is not a Late Enrollee and is not subject to the Waiting Period.

(3) The Special Enrollment right requires:

a. If the other coverage is COBRA continuation, the Special Enrollment request is available only after exhausting the maximum eligible duration of COBRA coverage.

b. If the other coverage is not COBRA continuation, the Special Enrollment request is available only after losing eligibility for the other coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or after cessation of Employer contributions for the other coverage.

(4) The Special Enrollment right does not apply if the Participant loses other coverage as a result of failure to pay premiums or for cause, such as (but not limited to) making a fraudulent claim.

(5) The effective date of coverage under this Plan shall be:

a. if enrollment in this Plan occurs not more than 30 days following the loss of other coverage, the date of losing other coverage; or

b. if enrollment in this Plan occurs more than 30 days following the loss of other coverage, the date of enrollment in this Plan. In this event, the enrollee(s) are subject to Late Enrollee provisions.

Dependent Special Enrollment

(1) A Dependent Special Enrollment right exists for Eligible Employees and Dependents upon the acquisition of a new Dependent through marriage, birth of a child, adoption of a child, or placement of a child for adoption. To qualify for the Dependent Special Enrollment right, the Employee must request the Dependent Special Enrollment and complete any required Enrollment Forms under this Plan not more than 30 days following the acquisition of a new Dependent.

(2) Eligible Employees and Spouses who previously declined coverage may also enroll under the Dependent Special Enrollment right, provided they are otherwise eligible.

(3) A person who enrolls under the provisions for Dependent Special Enrollment is not a Late Enrollee and is not subject to the Waiting Period.

(4) The effective date of coverage under this Plan in the case of Dependent Special Enrollment shall be:

a. if enrollment in this Plan occurs not more than 30 days following the loss of other coverage, the date of losing other coverage; or

b. if enrollment in this Plan occurs more than 30 days following the loss of other coverage, the date of enrollment in this Plan. In this even, the enrollee(s) are subject to Late Enrollee provisions.

For a newborn or adopted child, coverage is retroactive to the date of birth or date of adoption.

Medicaid and CHIP Special Enrollment/Special Enrollees

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

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

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

Termination of Coverage

Coverage of an Employee or Dependent ends when the first of the following events takes place.

(1) the date the Plan ends;

(2) the date the Participant is no longer in an eligible class or satisfies the definitions of eligibility as stated in the Eligibility Provisions of this Plan;

(3) the date the Plan is changed to end benefits for the class to which the Participant belongs;

(4) the end of the period for which the Participant no longer satisfies the Contributory cost requirement established by the Employer; or

(5) the end of the month in which employment is terminated; or

(6) the day of the Plan Month in which the Participant requests such coverage be terminated.

The same rules of termination apply to the end of Dependent coverage.

For Retirees and covered Dependents of Retirees, there are terminations of coverage events that are in addition to the other termination of coverage events stated in this paragraph:

(7) Upon attaining age 65.

(8) Upon becoming eligible for Medicare.

(9) Upon becoming eligible for other group coverage.

In addition to any other Termination of Coverage provisions, a student will terminate on the earliest of the dates described as follows:

(1) the date any of the dependent criteria are no longer satisfied;

The end of coverage will not affect any claim made for benefit while a Participant.

Continuation of Eligibility

The Plan provisions for an Employee to extend participation during a period of Disability, Lay-Off or Employer approved Leave of Absence are described as follows:

(1) During a period of Disability, eligibility to participate shall extend for a period not to exceed eighteen months.

(2) During a period of Lay-Off, eligibility to participate shall extend for a period not to exceed two months.

(3) For Employees changing from full-time employment to part-time employment, eligibility to participate shall extend for a period not to exceed two months.

(4) During a period of Employer Approved Leave of Absence, eligibility to participate shall extend for a period not to exceed twelve months.

(5) For Early Retirement, eligibility to participate shall extend for a period not to exceed eighteen months.

In the case of a Lay Teacher, the early Retiree must meet the rule of 85. In order to satisfy the Rule of 85, You must be at least 62 years old when You leave and the sum of Your age and years of vesting service must equal 85 or more.

(6) A period of continued participation under these provisions for Continuation of Eligibility shall apply toward the maximum duration of coverage provisions included in the Family Medical Leave Act of 1993.

(7) Continuation to participate requires timely payment of any required contributions to the Employer. Coverage will not extend beyond the end of the period for which the Employer has received payment of the required contribution.

Continuation of Coverage Due to Family and Medical Leave (FMLA)

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

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

If the employee chooses to continue coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same premium contribution ratio. If the employee's premium for continued membership in the

Plan is more than 30 days late, the Employer will send written notice to the employee. It will tell the employee that his or her membership will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

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

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

Coverage During Military Leave Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)

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

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

HOW TO OBTAIN COVERED SERVICES

Network Services and Benefits

If Your care is rendered by a Network Provider, benefits will be provided at the Network level. The Claims Administrator is allowed by the Employer to determine whether services or supplies are Medically Necessary and to determine the Medical Necessity of the service or referral to be arranged.

The Claims Administrator, on behalf of the Employer, may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other Facility. This decision is made upon review of Your condition and treatment.

If the type of Provider is not included in the Network, contact the Claims Administrator. The Claims Administrator, on behalf of the Employer, may approve a Non-Network Provider for that service as an Authorized Service. Network Providers are described below:

- **Network Providers** include Physicians, Professional Providers, Hospitals and Facility Providers who contract with the Claims Administrator, on behalf of the Employer, to perform services for You.

  For services rendered by Network Providers:

  – You will not be required to file any claims for services You obtain directly from Network Providers. **Network Providers will seek compensation for Covered Services rendered from the Plan and not from You except for approved percentage Coinsurance and/or Deductibles.** You may be billed by Your Network Provider(s) for any non-Covered Services You receive or where You have not acted in accordance with this Plan.

  – Health Care Management is the responsibility of the Member.

Contact Your Network Provider or the Claims Administrator, on behalf of the Employer, to be sure that Prior Authorization and/or Precertification has been obtained.

Non-Network Services

Services which are not obtained from a Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care and Urgent Care. In addition, certain services are not covered unless obtained from a Network Provider; see Your **Schedule of Benefits.**

For services rendered by a Non-Network Provider, You are responsible for:

(1) obtaining any Precertification, which is required;

(2) filing claims; and

(3) higher cost sharing amounts.

If there is no Network Provider who is qualified to perform the treatment You require, contact the Claims Administrator prior to receiving the service or treatment and the Claims Administrator, on behalf of the Employer, and may approve a Non-Network Provider for that service as an Authorized Service.

Relationship of Parties (Claims Administrator - Network Providers)

The relationship between the Claims Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Claims Administrator, nor is the Claims Administrator, or any employee of the Claims Administrator, an employee or agent of Network Providers.

The Claims Administrator shall not be responsible for any claim or demand as a result of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

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

Not Liable for Provider Acts or Omissions

The Claims Administrator and/or the Employer are not responsible for the actual care You receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Claims Administrator and/or the Employer based on what a Provider of health care, services or supplies, does or does not do.

Identification Card

When You receive care from Your Network Provider or other Provider, You must show Your Identification Card. Possession of an Identification Card confers no right to services or other benefits under the Plan. To be entitled to such services or benefits You must be a Member on whose behalf all applicable Fees under the Plan have been paid. Any person receiving services or other benefits to which he or she is not then entitled under the provisions of the Plan will be responsible for the actual cost of such services or benefits.

HEALTH CARE MANAGEMENT - PRECERTIFICATION

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to determine when services should be covered by Your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

Prior Authorization: Network Providers are required to obtain prior authorization in order for You to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The Claims Administrator may determine that a service that was initially prescribed or requested is not Medically Necessary if You have not previously tried alternative treatments which are more cost effective.

If You have any questions regarding the information contained in this section, You may call the Precertification telephone number on Your Identification Card or visit www.anthem.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, You, Your authorized representative or Physician must notify the Claims Administrator within two business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination – An optional, voluntary Prospective or Concurrent/Continued Stay Review request for a benefit coverage determination for a service or treatment. The Claims Administrator will review Your Plan to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Plan or is Experimental/Investigative as that term is defined in this Plan.

Post Service Clinical Claims Review – A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which the Claims Administrator has a related clinical coverage guideline and are typically initiated by the Claims Administrator.

Failure to Obtain Precertification Penalty

IMPORTANT NOTE: IF YOU OR YOUR NON NETWORK PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, A $300 PENALTY WILL APPLY AND THE PLAN'S REIMBURSEMENT WILL BE REDUCED. THIS DOES NOT APPLY TO MEDICALLY NECESSARY SERVICES FROM A NETWORK OR BLUECARD PROVIDER.

This list is subject to change; please call the Precertification telephone number on Your ID Card to confirm.

Inpatient Admission:

- All acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehabilitation, and Obstetrical delivery stays beyond the 48/96 hour Federal mandate length of stay minimum (including newborn stays beyond the mother's stay)
- Emergency Admissions (requires Plan notification no later than two business days after admission)

Outpatient Services:

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bariatric surgery
- Bone-Anchored Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, Reduction, Mastectomy for Gynecomastia and other Breast Procedures
- Canaloplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain Stimulation
- Diagnostic Testing
    - Diagnosis of Sleep Disorders
    - Gene Expression Profiling for Managing Breast Cancer Treatment
    - Genetic Testing for Cancer Susceptibility

- DME/Prosthetics
    - Bone Growth Stimulator: Electrical or Ultrasound
    - Communication Assisting / Speech Generating Devices
    - External (Portable) Continuous Insulin Infusion Pump
    - Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
    - Microprocessor Controlled Lower Limb Prosthesis
    - Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
    - Pneumatic Pressure Device with Calibrated Pressure
    - Power Wheeled Mobility Devices
    - Prosthetics: Electronic or externally powered and select other prosthetics
    - Standing Frame
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Implantable or Wearable Cardioverter-Defibrillator (ICD)
- Implantable Infusion Pumps
- Implantable Middle Ear Hearing Aids
- Implanted Devices for Spinal Stenosis
- Implanted Spinal Cord Stimulators
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
- Lumbar spinal surgeries
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Maze Procedure
- MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
- Oral, Pharyngeal & Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
- Surgical Treatment of Migraine Headaches
- Occiptal nerve stimulation
- Orthognathic Surgery
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Back Pain
- Photocoagulation of Macular Drusen
- Physician Attendance and Supervision of Hyperbaric Oxygen Therapy

- Plastic/Reconstructive surgeries:
    - Abdominoplasty, Panniculectomy, Diastasis Recti Repair
    - Blepharoplasty
    - Brachioplasty
    - Buttock/Thigh Lift
    - Chin Implant, Mentoplasty, Osteoplasty Mandible
    - Insertion/Injection of Prosthetic Material Collagen Implants
    - Liposuction/Lipectomy
    - 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
    - Rhinoplasty
    - Skin-Related Procedures
- Percutaneous Spinal Procedures
- Private Duty Nursing
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Radiation therapy
    - Intensity Modulated Radiation Therapy (IMRT)
    - Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Thoracoscopy for Treatment of Hyperhidrosis
- Tonsillectomy in Children
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transmyocardial Preventicular Device
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Wearable Cardioverter Defibrillators

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admissions for **ALL** solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- All Outpatient services for the following:
    - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
    - Donor Leukocyte Infusion

Out of Network Referrals:

Requests for Out of Network Referrals for care that the Claims Administrator determines are Medically Necessary may be pre-authorized, based on network adequacy and Medical Necessity.

Mental Health/Substance Abuse (MHSA):

Precertification Required

- Acute Inpatient Admissions
- Electric Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
    - Intensive Outpatient Therapy (IOP)
    - Partial Hospitalization (PHP)
- Residential Care
- ABA- Applied Behavioral Analysis
- Residential Treatment Centers (RTC)

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

Who is responsible for Precertification?	
Services provided by a Network Provider, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company.	**Services provided by BlueCard providers outside the service areas of the states listed in the column to the left, BlueCard providers in other states not listed, and any Non-Network/Non-Participating Provider.**
Provider is responsible for Precertification.	• Member is responsible for Precertification. • Member is financially responsible for service and/or setting that are/is not covered under this Plan based on an Adverse Determination of Medical Necessity or Experimental/Investigative.

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

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

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

In addition, the Claims Administrator may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt Your claim from medical review if certain conditions apply.

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

You may determine whether a Provider is participating in certain programs by contacting the customer service number on the back of Your ID Card.

The Claims Administrator 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 the Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Request Categories:

- **Urgent –** a request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the member to severe pain that cannot be adequately managed without such care or treatment.
- **Prospective –** a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.
- **Concurrent/Continued Stay Review -** a request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective -** a request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Review 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 Notification Requirements

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

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

Request Category	Timeframe Requirement for Decision and Notification
Concurrent/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
Concurrent/Continued Stay Review Non-Urgent for ongoing outpatient treatment	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If additional information is needed to make a decision, the Claims Administrator will notify the requesting Provider and send written notification to You or Your authorized representative of the specific information necessary to complete the review. If the Claims Administrator does not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in the Claims Administrator's possession.

The Claims Administrator will provide notification of its decision in accordance with federal regulations. Notification may be given by the following methods:

- **Verbal:** oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.
- **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the Member or authorized Member representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date You receive service:

1. You must be eligible for benefits;
2. the service or surgery must be a Covered Service under Your Plan; and
3. the service cannot be subject to an exclusion under Your Plan
4. You must not have exceeded any applicable limits under Your Plan.

Health Plan Individual Case Management

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

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

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

In addition, the Claims Administrator may assist in coordinating care with existing community-based programs and services to meet Your needs. This may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, the Plan may provide benefits for alternate care that is not listed as a Covered Service. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Claims Administrator's will make any recommendation of alternate or extended benefits to the Plan on a case-by-case basis, if in the Claims Administrator's discretion the alternate or extended benefit is in the best interest of the Member and the Plan. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to You or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, the Claims Administrator will notify You or Your authorized representative in writing.

COVERED SERVICES

This section describes the Covered Services available under Your health care benefits when provided and billed by Providers. **Care must be received from a Network Provider to be covered at the Network level, except for Emergency Care and Urgent Care. Services which are not received from a Network Provider will be considered a Non-Network Service, unless otherwise specified in this Benefit Booklet.** The amount payable for Covered Services varies depending on whether You receive Your care from a Network Provider or a Non-Network Provider.

If You use a Non-Network Provider, You are responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable percentage Coinsurance or Deductible. The Claims Administrator or the Employer cannot prohibit Non-Network Providers from billing You for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Benefit Booklet, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, You must follow the terms of the Benefit Booklet, including use of Network Providers, and obtain any required Prior Authorization or Precertification. Contact Your Network Provider to be sure that Prior Authorization/Precertification has been obtained. The Claims Administrator, on behalf of the Employer, bases its decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on the Claims Administrator's medical policy and Clinical Guidelines. The Claims Administrator, on behalf of the Employer, may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Benefit Booklet. Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Plan payment for Covered Services will be limited by any applicable percentage Coinsurance, Deductible, or Benefit Period maximum in this Benefit Booklet.

Preventive Care Services

Preventive Care benefits may vary based on the age, sex, and personal history of the individual, and as determined appropriate by the Claims Administrator's clinical coverage guidelines. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening

or service. **Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.**

Some examples of Preventive Care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. **(Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.)** Examinations include, but are not limited to:

    1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines.
    2. Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.
    3. Routine checkups – 6 exams up to age 2.
    4. Physical exams – 1 per calendar year.
    5. Pelvic examinations.
    6. Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.
    7. Annual dilated eye examination for diabetic retinopathy.
    8. Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follow the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians. These include, but are not limited to:

        - Hepatitis A vaccine
        - Hepatitis B vaccine
        - Hemophilus influenza b vaccine (Hib)
        - Influenza virus vaccine
        - Rabies vaccine
        - Diphtheria, Tetanus, Pertussis vaccine
        - Mumps virus vaccine
        - Measles virus vaccine
        - Rubella virus vaccine
        - Poliovirus vaccine

- **Screening examinations:**

    1. One routine screening mammograms per calendar year; Additional mammography views required for proper evaluation and any ultrasound services for screening of breast cancer, if determined Medically Necessary by Your Physician, are also covered;
    2. One routine pap smear per calendar year;
    3. One routine bone density testing for women per calendar year;
    4. One routine prostate specific antigen testing per calendar year;
    5. One routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by Your Physician.

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.

Physician Office Services

Office Services include care in a Physician's office that is not related to Maternity and Mental Health Conditions, except as specified. Refer to the sections entitled **Maternity Services** and **Behavioral Health Care** for services covered by the Plan. **For Emergency Accident or Medical Care** refer to the **Emergency Care and Urgent Care** section.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits include injections including allergy injections.

Diagnostic Services when required to diagnose or monitor a symptom, disease, or condition.

Surgery and Surgical services including anesthesia and supplies. The surgical fee includes normal post-operative care.

Therapy Services for Physical Medicine Therapies and Other Therapies when rendered in the office of a Physician or other professional Provider.

Inpatient Services

Inpatient Services do not include care related to Maternity and Mental Health Conditions, except as specified. Refer to the sections entitled **Maternity Services** for services covered by the Plan. Inpatient Services include:

- charges from a Hospital or other Provider for room, board and general nursing services;
- ancillary services; and
- professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- a room with two or more beds;
- a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that You occupy a private room for isolation and no isolation facilities are available;
- a room in a special care unit approved by the Claims Administrator, on behalf of the Employer. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary Services

- operating, delivery and treatment rooms and equipment;
- prescribed drugs;
- anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider;
- medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services; and
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care for** constant attendance and treatment when Your condition requires it for a prolonged time.

- **Concurrent care** for a medical condition by a Physician who is not Your surgeon while You are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of Your condition requires the skills of separate Physicians.

- **Consultation** which is a personal bedside examination by another Physician when requested by Your Physician. Staff consultations required by Hospital rules are excluded.

- **Surgery and the administration of general anesthesia**.

- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Outpatient Services

Outpatient Services include **both facility and professional charges** when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. Outpatient Services do not include care that is related to Maternity Services, except as otherwise specified. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care Services** section.

Emergency Care and Urgent Care Services

Emergency Care
Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care for initial services rendered for the onset of symptoms for a life-threatening condition or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a 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 failure to obtain immediate medical care could place his or her life in danger or cause serious harm.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the Schedule of Benefits.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. Urgent Care services can be obtained from a Network or Non-Network Provider. If You experience an accidental injury or a medical problem, the Claims Administrator, on behalf of the Employer, will determine whether Your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on Your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an Emergency room at a Hospital. If You call Your Physician prior to receiving care for an urgent medical problem and Your Physician authorizes You to go to an Emergency room, Your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See Your Schedule of Benefits for benefit limitations.

Ambulance Services

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 and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

- For ground ambulance, You are taken:
  - From Your home, the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital;
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.

- For air or water ambulance, You are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital;
  - Between a Hospital and an approved Facility.

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

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

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

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

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

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

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

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

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

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

Diagnostic Services

Diagnostic services are tests or procedures generally performed when You have specific symptoms, to detect or monitor Your condition. Coverage for Diagnostic Services, including when provided as part of Preventive Care Services and Physician Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;

- Magnetic Resonance Imaging (MRI);

- CAT scans;

- Laboratory and pathology services;
- Cardiographic, encephalographic, and radioisotope tests;
- Ultrasound services;
- Allergy tests;
- Electrocardiograms (EKG);
- Electromyograms (EMG) except that surface EMG's are not Covered Services;
- Echocardiograms;
- Bone density studies;
- Positron emission tomography (PET scanning).

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Surgical Services

Coverage for Surgical Services when provided as part of Physicians Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by the Employer.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact the Claims Administrator for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, and laparoscopy;

- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Surgery
Precertification is required. Reconstructive surgery does not include any service otherwise excluded in this Benefit Booklet. (See "Limitations and Exclusions.")

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed 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: Coverage for reconstructive services does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Temporomandibular or Craniomandibular Joint disorder (TMJ)

For Temporomandibular or Craniomandibular Joint disorder and Craniomandibular the Plan covers appliances as DME and covers medically appropriate surgical procedures.

Reversal of Sterilization

Regardless of Medical Necessity, You are covered for reversal of sterilization, only. Sterilization is not covered.

Mastectomy Notice

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual Deductible and percentage Coinsurance provisions otherwise applicable under the Plan.

Therapy Services

Coverage for Therapy Services when provided as part of Physician Office Services, Inpatient Facility Services, Outpatient Services, or Home Care Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.

- **Speech therapy** for the correction of a speech impairment.

- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).

- **Spinal manipulation services** to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulation whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Spinal Manipulations as specified in the Schedule of Benefits.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning and maintenance are not covered.

- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.

- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes.

- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Certain Therapy Services rendered on an Inpatient or Outpatient basis are limited. See the Schedule of Benefits.

Home Care Services

Services performed by a Home Health Care Agency or other Provider in Your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.);
- Diagnostic Services;
- Medical/Social Services;
- Nutritional Guidance;
- Home Health Aide Services;
- Therapy Services (Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.);
- Medical/Surgical Supplies;
- Durable Medical Equipment;
- Prescription Drugs (only if provided and billed by a Home Health Care Agency);
- Private Duty Nursing.

Home infusion therapy will be paid only if You obtain prior approval from the Claims Administrator's Home Infusion Therapy Subcontractor (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home

IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

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.

Your Doctor and Hospice medical director must certify that You are terminally ill and likely have less than 12 months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

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 Benefit Booklet.

Human Organ and Tissue Transplant Services

Notification

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

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

Covered Transplant Benefit Period
Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Claims Administrator for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.

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

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

Transportation and Lodging
The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when

claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Medical Supplies, Durable Medical Equipment, and Appliances

The supplies, equipment, and appliances described below are Covered Services under this benefit. If the supplies, equipment, and appliances include comfort, luxury, or convenience items or features, which exceed what is Medically Necessary in Your situation or needed to treat Your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item, which is a Covered Service, is Your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates Your condition.
Covered Services include, but are not limited to:

- **Medical and surgical supplies** - Syringes, needles, oxygen, surgical dressings, splints and other similar items, which serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly. Prescription drugs and biologicals that cannot be self administered and are provided in a Physician's office.

- **Durable medical equipment** - The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. **Non-covered** items include but are not limited to air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports, and corsets or other articles of clothing.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

    1. Replace all or part of a missing body part and its adjoining tissues; or
    2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Covered Services for prosthetic appliances include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant);
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act;
4. Minor devices for repair such as screws, nails, sutures and wire mesh;
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session);
7. Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract - formulae and supplies are also covered);
8. Cochlear implant;
9. Electronic speech aids in post-laryngectomy or permanently inoperative situations;
10. "Space Shoes" when used as a substitute device when all or a substantial portion of the forefoot is absent;
11. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth;
2. Dental appliances;
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4. Artificial heart implants;
5. Hairpieces for male pattern alopecia (baldness);
6. Wigs (except as described above following cancer treatment).

- **Orthotic devices** – Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part . The cost of casting, molding, fittings, and adjustments are included.

Covered orthotic devices include, but are not limited to, the following:

1. Cervical collars;
2. Ankle foot orthosis;
3. Corsets (back and special surgical);
4. Splints (extremity);
5. Trusses and supports;
6. Slings;
7. Wristlets;
8. Built-up shoe;
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes;
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
4. Garter belts or similar devices.

Accident Related Dental Services

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

Treatment must be completed within the timeframe shown in the Schedule of Benefits.

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

- The Member is under the age of five (5);
- The Member has a severe disability that requires hospitalization or general anesthesia for dental care; or
- The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Oral Surgery
Covered Services include only the following:

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

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:

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

Maternity Services

Maternity Services include Inpatient Services, Outpatient Services and Physician Office Services for normal pregnancy, complications of pregnancy, miscarriage, and ordinary routine nursery care for a well newborn.

If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for You and Your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if Your attending Physician determines further Inpatient postpartum care is not necessary for You or Your newborn child, provided the following are met and the mother concurs:

- In the opinion of Your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

    1. The antepartum, intrapartum, and postpartum course of the mother and infant;
    2. The gestational stage, birth weight, and clinical condition of the infant;
    3. The demonstrated ability of the mother to care for the infant after discharge; and
    4. The availability of postdischarge follow-up to verify the condition of the infant after discharge.

- Covered Services include at-home post delivery care visits at Your residence by a Physician or Nurse when performed no later than 48 hours following You and Your newborn child's discharge from the Hospital. Coverage includes, but is not limited to:

    1. Parent education;
    2. Physical assessments;
    3. Assessment of the home support system;
    4. Assistance and training in breast or bottle feeding;
    5. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for You or Your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At Your discretion, this visit may occur at the Physician's office.

If a non-member is pregnant with a baby that is to be adopted by a diocese member of the Diocese's plan, the non-member may be eligible for maternity benefits under the following circumstances:

- The child is adopted by the Diocese member within one year of birth.
- The Diocese member is legally obligated to pay the costs of the birth for both the birth mother and the child to be adopted.
- The member notifies the Diocese that a court has certified the member as acceptable to adopt within 60 days of the court order or the effective date of this plan, whichever occurs first.

The payment for the birth mother who is a non-Diocese member covers the hospital stay/delivery for both the birth mother and child. If complications occur for the birth mother, the Diocese will only pay for the birth of the child. If the birth mother has coverage, the Diocese coverage would be secondary. If no coverage for the birth mother, the Diocese's plan would be primary.

Behavioral Health Care

See the Schedule of Benefits for any applicable Deductible, or Coinsurance information.

Coverage for the treatment of Behavioral Health and Substance Abuse Services is provided in compliance with federal law.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation, therapy, and education.

Examples of Providers from whom You can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- 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) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

EXCLUSIONS

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. This list of Exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The Plan does not provide benefits for services or supplies:

1. Which are determined not Medically Necessary or do not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

2. Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet or recognized by the Plan.

3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Claims Administrator, on behalf of the Employer.

4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to You, or if Workers' Compensation benefits are available to You and You have the option to not participate and choose not to participate, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.

5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

6. For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.

7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

8. For care, required while incarcerated in a federal, state, or local penal institution or required while in custody of federal, state or local law enforcement authorities, unless otherwise required by law or regulation.

9. For Prescription Drug Copayments or Deductibles You are responsible for under other coverage with other carriers or health plans.

10. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

11. For court ordered testing or care.

12. For which You have no legal obligation to pay in the absence of this or like coverage.

13. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

14. Prescribed, ordered, or referred by, or received from a member of Your immediate family, including Your spouse, child, brother, sister, parent, or self.

15. For completion of claim forms or charges for medical records or reports unless otherwise required by law.

16. For missed or canceled appointments.

17. For mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the Employer.

18. Services paid under Medicare or which would have been paid if the Member had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payer whether or not the Member has enrolled Medicare Part B. For services provided pursuant to a private contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

19. Charges in excess of the Maximum Allowable Amount.

20. Incurred prior to Your Effective Date.

21. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.

22. For any procedures, services, equipment, or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change, or improve Your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of Your skin or to change the size, shape or appearance of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a

Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law.

23. Services, which are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury, or condition, which is resolved or stable.

24. For Custodial Care, Domiciliary Care or convalescent care, whether or not recommended or performed by a professional.

25. For foot care only to improve comfort or appearance including, but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails except when Medically Necessary including but not limited to, foot care for diagnosis of diabetes or for impaired circulation to the lower extremities.

26. For any treatment of teeth, gums or tooth related service except as otherwise specified as covered in this Benefit Booklet.

27. Related to weight loss or weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss) or fasting programs.

28. For sex transformation surgery and related services, or the reversal thereof.

29. For marital counseling.

30. For Family Therapy.

31. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

32. For hearing aids or examinations for prescribing or fitting them.

33. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

34. For artificial insemination, fertilization (such as in vitro or GIFT) or procedures and testing related to fertilization, infertility drugs and related services following the diagnosis of infertility.

35. For personal hygiene and convenience items.

36. For care received in an emergency room, which is not Emergency Care, except as specified in this Benefit Booklet.

37. For expenses incurred at a health spa or similar facility.

38. For self-help training and other forms of non-medical self-care, except as otherwise provided herein.

39. For examinations relating to research screenings.

40. For stand-by charges of a Physician.

41. For physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

42. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy.

43. Related to any mechanical equipment, device, or organ.

44. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility.

45. For Private Duty Nursing Services except when provided through the Home Care Services benefit.

46. For services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs**,** and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

47. Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

49. For drugs in quantities, which exceed the limits established by the Plan.

50. For elective or therapeutic abortions.

51. For Prescription Legend Drugs or Home Delivery (Mail Service) Pharmacy drugs.

52. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with Sclerotherapy.

53. Treatment of telangiectatic dermal veins (spider veins) by any method.

54. No Benefits are available for services that are not specifically described as Covered Services in this Benefit Booklet. This exclusion applies even if Your Physician orders the service.

55. For supervised living or half-way houses.

56. For room and board charges unless the treatment provided meets the Claims Administrator's Medical Necessity criteria for Inpatient admission for Your condition.

57. For military service for any country or organization and service with military or paramilitary forces as a civilian.

58. For charges for eye refractions, glasses, contact lenses, hearing aids or hearing devices except the first pair of either glasses or contact lenses needed after cataract surgery.

59. For routine medical care, examinations, nutritional supplements, or immunizations except as provided for under preventive health care procedures described in the Schedule of Benefits section of this document.

60. For charges for Hospital confinement that occurs primarily for physiotherapy, hydrotherapy, convalescent care, routine physical examinations or tests not related to a diagnosed Sickness or Injury.

61. For charges for services outside the United States if the Participant traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.

62. For charges for complications that are the result of or related to treatment or procedures that are ineligible for coverage under this Plan.

63. For direct treatment to the teeth or periodontium shall be considered dental services and are excluded from the medical portion of this Plan.

64. For birth control medications, injectables or devices.

65. For charges to the extent reimbursement of medical expense occurs from any policy of automobile, homeowners, commercial or any other similar insurance coverage, or arrangement.

66. For charges for complications that are the result of or related to treatment or procedures that are ineligible for coverage under this Plan.

67. For Orthotics, unless custom made.

68. For Lasik Eye Surgery.

69. For smoking cessation.

70. Services of a Physician employed by any government unless a charge must be paid by the Participant.

71. Charges for Voluntary Sterilization procedures.

72. Waived Cost-Shares Out-of-Network - For any service for which You are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

73. Waived Fees - Any portion of a Provider's fee or charge which is ordinarily due from a Member but which has been waived. If a Provider routinely waives (does not require the Member to pay) a Deductible or Out-of-Pocket amount, the Claims Administrator will calculate the actual Provider fee or charge by the amount waived.

CLAIMS PAYMENT

How to Obtain Benefits

When Your care is rendered by a Network Provider You are not required to file a claim. Therefore, provisions below regarding "Claim Forms" and "Notice of Claim" do not apply, unless the claim was not filed by the Provider.

For services received from a Non-Network Provider, You are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit Your claim for You. If You submit the claim use a claim form.

Maximum Allowed Amount

General

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

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

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

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

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means Claims Administrator has

determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

Provider Network Status

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

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

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

For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

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

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or

4. An amount negotiated by the Claims Administrator or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or

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

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

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

Customer Service is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator 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 Customer Service can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

Member Cost Share

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

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network

Providers. Please see the Schedule of Benefits in this Benefit Booklet for Your cost share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or cost share amounts may vary by the type of Provider You use.

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

In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is not employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

Authorized Services

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

Services Performed During Same Session

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

Continuous Coverage

If You were previously covered by a Plan with the Employer and with the Claims Administrator with no break in coverage, You will receive credit for any accrued Deductibles and Out-of-Pocket amounts. However, any maximums used under that Plan will be carried over and charged against the maximums of the Plan.

Payment of Benefits

You authorize the Claims Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. The Claims Administrator, on behalf of the Employer, also reserves the right to make payments directly to You. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by the Claims Administrator, on behalf of the Employer, will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by any applicable state or Federal law.

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

Assignment

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

Notice of Claim

The Plan is not liable, unless the Claims Administrator, on behalf of the Employer, receives written notice that Covered Services have been given to You. An expense is considered incurred on the date the service or supply was given. The notice must be given to the Claims Administrator within 15 months of receiving the Covered Services, and must have the data the Claims Administrator needs to determine benefits. If the notice submitted does not include sufficient data the Claims Administrator needs to process the claim, then the necessary data must be submitted to the Claims Administrator within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If the Claims Administrator has not received the information it needs to process a claim, the Claims Administrator will ask for the additional information necessary to complete the claim. Generally, You will receive a copy of that request for additional information, for Your information. In those cases, the Claims Administrator cannot complete the processing of the claim until the additional information requested has been received. The Claims Administrator generally will make its request for additional information within 30 days of the Claims Administrator's initial receipt of the claim and will complete its processing of the claim within 15 days after the Claims Administrator's receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give the Claims Administrator notice within 15 months of receiving the Covered Services will not reduce any benefit if You show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 15 months of receiving the Covered Services filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Many Providers will file for You. If the forms are not available, either send a written request for claim forms to the Claims Administrator or the Employer, or contact customer service and ask for claim forms to be sent to You. The form will be sent to You within 15 days. If You do not receive the forms, written notice of services rendered may be submitted to the Claims Administrator, on behalf of the Employer, without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

Time Benefits Payable

The Plan will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by You or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If the Claims Administrator has not received the information needed to process a claim, the Claims Administrator, on behalf of the Employer, will ask for the additional information necessary to complete the claim. Generally, You will receive a copy of that request for additional information, for Your information. In those cases, the Claims Administrator cannot complete the processing of the claim until the additional information requested has been received. The Claims Administrator, on behalf of the Employer, generally will make a request for additional information within 30 days of the Claims Administrator or Employer's initial receipt of the claim and will complete processing of the claim within 15 days after the Claims Administrator's receipt of all requested information.

At the Employer's discretion, benefits will be paid to You or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, the Plan may reimburse those other parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to the Claims Administrator, on behalf of the Employer, such authorizations, consents, releases, assignments and other documents as may be requested by the Claims Administrator, in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payer) will be responsible for any charge for services.

Claims Review

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

Explanation of Benefits

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

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

Inter-Plan Programs

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain healthcare services outside of Anthem'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 Anthem and other Blue Cross and Blue Shield Licensees.

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

BlueCard® Program

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

Whenever You access covered healthcare services outside Anthem'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 Anthem.

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 Anthem uses for Your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws 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, the Claims Administrator would then calculate Your liability for any covered healthcare services according to applicable law.

You will be entitled to benefits for healthcare services that You accessed either inside or outside the geographic area Anthem serves, if this Booklet 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 Anthem serves, even though You might not otherwise have been entitled to benefits if You had received those healthcare services inside the geographic area Anthem serves. But in no event will You be entitled to benefits for healthcare services, wherever You received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Plan.

Non-Participating Healthcare Providers Outside Anthem's Service Area

Member Liability Calculation

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

Exceptions

In certain situations, the Claims Administrator may use other payment bases, such as billed covered charges, the payment the Administrator would make if the healthcare services had been obtained within the Claims Administrator's Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Administrator will pay for services rendered by nonparticipating healthcare providers. In these situations, You may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment the Claims Administrator 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 Allowable Amount. You may call the Customer Service number on Your ID Card or go to www.anthem.com for more information about such arrangements.

Unauthorized Use of Identification Card

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

Assignment

You authorize the Claims Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. The Claims Administrator also reserves the right to make payments directly to You. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by the Claims Administrator will discharge the

Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable Federal law.

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

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

Questions About Coverage or Claims

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Customer Service Department. Be sure to always give Your Member Identification number.

When asking about a claim, give the following information:

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

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

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

An oral explanation of Your benefits by an employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

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

GENERAL PROVISIONS

Entire Agreement

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

Form or Content of Benefit Booklet

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

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with Your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If You refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, You will be so advised. In such case, neither, the Claims Administrator, Employer, nor any Provider shall have any further responsibility to pay benefits or provide care for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

The Claims Administrator, on behalf of the Employer, shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Claims Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the

Plan is delayed or rendered impractical the Claims Administrator, on behalf of the Employer, shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer's Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer's rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As an Claims Administrator of Your Employer's Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem's Notice, contact the customer service number on the back of Your Identification Card.

Coordination of Benefits

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

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

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

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

COB Definitions

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

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

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

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

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

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

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense;

however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.

5. The amount that is subject to the Primary high-deductible health plan's deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

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

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

Order of Benefit Determination Rules

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

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

1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

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

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

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

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

   - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;

   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or

   - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

     - The Plan covering the Custodial parent;

     - The Plan covering the spouse of the Custodial parent;

     - The Plan covering the non-custodial parent; and then

     - The Plan covering the spouse of the non-custodial parent.

3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other federal law and are covered under another Plan, the Plan covering You as an employee, member, subscriber or retiree or covering You as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits. <u>This rule does not apply</u> when the person is covered either: (a) as a non- dependent under both Plans (i.e. the person is covered

under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own Plan as an employee, member, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a dependent of an employee, member or subscriber or retired employee and is covered under the other plan as a dependent of an employee, member, subscriber or retiree).

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

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

Effect on the Benefits of this Plan

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

Medicare Program

When You are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payer, the benefits described in this Benefit Description will be reduced by the amount of benefits allowed under Medicare for the same *covered services*. This reduction will be made whether or not You actually receive the benefits from Medicare.

- **If You Are Under Age 65 With End Stage Renal Disease (ESRD)**
  If You are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This includes the Medicare "three month waiting period" and the additional **30 months** after the Medicare effective date. After 33 months, the benefits described in this Benefit Description will be reduced by the amount that Medicare allows for the same *covered services*.

- **If You Are Under Age 65 With Other Disability**
  If You are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This is the case **only** if You are the actively employed S*ubscriber* or the enrolled Spouse or child of the actively employed S*ubscriber*.

- **If You Are Age 65 or Older**
  If You are age 65 or older and eligible for Medicare only because of age, the Plan will provide the benefits described in this Benefit Description before Medicare. This can be the case only if You are an actively employed Subscriber or the enrolled Spouse of the actively employed Subscriber.

Workers' Compensation

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

Other Government Programs

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

Subrogation and Right of Reimbursement

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

Recovery

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

Subrogation

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

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

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

- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.

- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

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

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.

- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to Your negligence.

- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

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

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

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

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

- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

Your Duties

- You must 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. In the event that You or Your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- You must not do anything to prejudice the Plan's rights.

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to You.

- You must promptly notify the Plan if You retain an attorney or if a lawsuit is filed on Your behalf.

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

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person that Recovery shall be subject to this provision.

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

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

Right of Recovery

Whenever payment has been made in error, the Claims Administrator, on behalf of the Employer, will have the right to recover such payment from You or, if applicable, the Provider. The Claims Administrator, on behalf of the Employer, reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

The Claims Administrator, on behalf of the Employer, has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The Claims Administrator, on behalf of the Employer, may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. The Claims Administrator, on behalf of the Employer, has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. The Claims Administrator, on behalf of the Employer, will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The Claims Administrator, on behalf of the Employer, may not provide You with notice of overpayments made by the Plan or You if the recovery method makes providing such notice administratively burdensome.

Relationship of Parties (Employer-Member-Claims Administrator)

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

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

Anthem Insurance Companies, Inc. Note

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

Notice

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

Modifications

This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, and provisions hereof.

Conformity with Law

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

Clerical Error

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

Policies and Procedures

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

Waiver

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

Employer's Sole Discretion

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

Reservation of Discretionary Authority

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

Governmental Health Care Programs

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

Medical Policy and Technology Assessment

The Claims Administrator 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 the Claims Administrator's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including the Claims Administrator'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.

COMPLAINT AND APPEALS PROCEDURES

The Claims Administrator's customer service representatives are specially trained to answer Your questions about Your health benefit Plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including percentage Coinsurance amounts;
- specific claims or services You have received;
- doctors or Hospitals in the Network;
- referral processes or authorizations; and/or
- Provider directories.

A complaint procedure has been established to provide fair, reasonable, and timely review of complaints that You may have concerning the Plan. The Claims Administrator invites You to share any concerns that You may have over benefit determinations, coverage cancellations, or the quality of care rendered by medical Providers in the Claims Administrator's Networks.

The Complaint Procedure

If You have a complaint, problem, or claim concerning benefits or services, please contact the Claims Administrator. Please refer to Your Identification Card for the Claims Administrator's telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Claims Administrator of its procedures and contracts. You may submit Your complaint by letter or by telephone call. Or, if You wish, You may meet with Your local service representative to discuss Your complaint. If Your complaint involves issues of Covered Services, You may be asked to sign a medical records release form so the Claims Administrator can request medical records for its review.

Your Right to Appeal

The Plan wants Your experience to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. In those cases, please contact Customer Service by calling the number on the back of Your ID Card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of Your complaint, You have the right to file an Appeal, which is defined as follows:

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

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

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

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

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

Notice of Adverse Benefit Determination

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

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA if You appeal and the claim denial is upheld;
- 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; and
- information regarding Your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify You or Your authorized representative within 24 hours orally and then furnish a written notification.

Appeals

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

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

For pre-service claims involving urgent/concurrent care, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:

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

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

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348.

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

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

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

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

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

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

External Review

If the outcome of the mandatory first level appeal is adverse to You, You may be eligible for an independent External Review pursuant to federal law.

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

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

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

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

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

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348.

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

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

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. If Your health benefit plan is sponsored by Your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Grandfathered Health Plan

This Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that Your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator or Your Employer.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., Your physician, nurse midwife, or physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your Out-of-Pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your Plan Administrator.

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

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

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

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

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

If You would like more information on WHCRA benefits, call Your Plan Administrator.

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

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

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day/visit limits on medical/surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day/visit limits for medical and surgical benefits. A plan that does not impose day/visit limits on medical and surgical benefits may not impose such day/visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment/Coinsurance and Out-of-Pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment/Coinsurance and Out-of-Pocket expenses applicable to other medical and surgical benefits.

Special Enrollment Notice

If You are declining enrollment for Yourself or Your Dependents (including Your spouse) because of other health insurance coverage, You may in the future be able to enroll Yourself or Your Dependents in this Plan, provided that You request enrollment within 31 days after Your other coverage ends. In addition, if You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll Yourself and Your Dependents in the Plan, 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 dependents. However, You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

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

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

To request special enrollment or obtain more information, call the Customer Service telephone number on Your ID Card, or contact Your Plan Administrator.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains Your rights. It also explains our legal duties and privacy practices. We are required by federal law to give You this notice.

Your Protected Health Information

We may collect, use, and share Your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage Your account or benefits; or to pay claims for health care You get through Your plan. For example, we keep information about Your premium and deductible payments. We may give information to a doctor's office to confirm Your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services You get. We may also use PHI to provide You with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as Your doctor or a hospital. But, we may share PHI with Your health care provider so that the provider may treat You.

To You: We must give You access to Your own PHI. We may also contact You to let You know about treatment options or other health-related benefits and services. When You or Your dependents reach a certain age, we may tell You about other products or programs for which You may be eligible. This may include individual coverage. We may also send You reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give Your PHI to someone else for any reason. Also, if You are present, and tell us it is OK, we may give Your PHI to a family member, friend or other person. We would do this if it has to do with Your current treatment or payment for Your treatment. If You are not present, if it is an emergency, or You are not able to tell us it is OK, we may give Your PHI to a family member, friend or other person if sharing Your PHI is in Your best interest.

As Allowed or Required by Law: We may also share Your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also

be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that You may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If You are enrolled with us through an employer sponsored group health plan, we may share PHI with Your group health plan. We and/or Your group health plan may share PHI with the sponsor of the Plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from You in writing before we use or share Your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using Your PHI for that purpose. But, if we have already used or shared Your PHI based on Your OK, we cannot undo any actions we took before You told us to stop.

Your Rights

Under federal law, You have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct Your PHI that You believe is missing or incorrect. If someone else (such as Your doctor) gave us the PHI, we will let You know so You can ask them to correct it.
- Send us a written request to ask us not to use Your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send Your PHI using other means that are reasonable. Also let us know if You want us to send Your PHI to an address other than Your home if sending it to Your home could place You in danger.
- Send us a written request to ask us for a list of certain disclosures of Your PHI.

Call Customer Service at the phone number printed on Your Identification (ID) Card to use any of these rights. They can give You the address to send the request. They can also give You any forms we have that may help You with this process.

How we protect information

We are dedicated to protecting Your PHI. We set up a number of policies and practices to help make sure Your PHI is kept secure.

We keep Your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep Your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without Your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide You with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If You think we have not protected Your privacy, You can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against You for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on Your ID Card. They can help You apply Your rights, file a complaint, or talk with You about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if You have agreed to get this notice by electronic means, You still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about You as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell You about any changes to our notice in a number of ways. We may tell You about the changes in a member newsletter or post them on our website. We may also mail You a letter that tells You about any changes.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

STATE NOTICE OF PRIVACY PRACTICES

As we told You in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains Your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share Your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about Your health, finances, character, habits, hobbies, reputation, career, and credit.

We may collect PI about You from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without Your OK in some cases.

If we take part in an activity that would require us to give You a chance to opt-out, we will contact You. We will tell You how You can let us know that You do not want us to use or share Your PI for a given activity.

You have the right to access and correct Your PI.

We take reasonable safety measures to protect the PI we have about You.

A more detailed state notice is available upon request. Please call the phone number printed on Your ID Card.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following companies:

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In most of Missouri: RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross and Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.