

HEALTH BENEFIT BOOKLET

**DIOCESE OF FORT WAYNE – SOUTH BEND, INC.
HSA PACKAGE 002
EFFECTIVE 1/1/2007**

BENEFIT BOOKLET

This Benefit Booklet has been prepared by the 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.

Administered by
Anthem Insurance Companies, Inc. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

TABLE OF CONTENTS

BENEFIT BOOKLET	2
TABLE OF CONTENTS.....	3
MEMBER RIGHTS AND RESPONSIBILITIES.....	4
SCHEDULE OF BENEFITS	6
DEFINITIONS	14
ELIGIBILITY, ENROLLMENT, TERMINATION, CONTINUATION AND CONVERSION	29
HOW TO OBTAIN COVERED SERVICES	39
HEALTH CARE MANAGEMENT	41
COVERED SERVICES.....	48
EXCLUSIONS.....	72
CLAIMS PAYMENT	78
GENERAL PROVISIONS	83
COMPLAINT AND APPEALS PROCEDURES.....	96
HIPAA NOTICE OF PRIVACY PRACTICES.....	100

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You Have the Right to:

- Receive information about the organization and its services, practitioners and Providers, and Members' rights and responsibilities;
- Be treated respectfully, with consideration and dignity;
- Receive all the benefits to which you are entitled under the Plan;
- Obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- Receive quality health care through your Provider in a timely manner and in a medically appropriate setting;
- Have a candid discussion with your Provider about treatment options, regardless of their cost or whether they are covered under the Plan;
- Participate with your Physician in decision making about your healthcare treatment;
- Refuse treatment and be informed by your Provider of the medical consequences;
- Receive wellness information to help you maintain a healthy lifestyle;
- Express concern and complaints about the care and services you received from a Provider, or the service you received from the Administrator, and to have the Administrator, on behalf of the Employer, investigate and take appropriate action;
- File a complaint with the Administrator, on behalf of the Employer, to appeal that decision as outlined in the **Complaint & Appeals** section of this Benefit Booklet, and to appeal a decision without fear of reprisal; and
- Privacy and confidential handling of your information;
- Make recommendations regarding the Administrator's rights and responsibilities policies; and
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.

As a Member, You Have the Responsibility to:

- Understand your health issues and be wise consumers of health care services;
- Use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship;
- Provide complete and honest information we need to administer benefits and that Providers need to care for you;
- Follow the plan and instructions for care that you and your Provider have developed and agreed upon;
- Understand how to access care in routine, Emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Deductibles, Coinsurance, etc.;
- Notify your Provider or the Administrator about concerns you have regarding the services or medical care you receive;
- Keep appointments for care and give reasonable notice of cancellations;
- Be considerate of other Members, Providers and the Administrator's staff;
- Read and understand your Benefit Booklet and Schedule of Benefits, and other materials from the Administrator or Employer concerning your health benefits;
- Provide accurate and complete information to the Administrator, on behalf of the Employer, about other health care coverage and/or insurance benefits you may carry; and
- Inform the Administrator and the Employer, of changes to your name, address, phone number, or if you want to add or remove Dependents.

Family Out-of-Pocket Limit.

- Once the Person and/or Family Out-of-Pocket Limit is satisfied, no additional percentage Coinsurance amounts will be required for the Person and/or Family for the remainder of the Benefit Period.
- Network and Non-Network Deductibles and Out-of-Pocket Limits **accumulate toward each other.**

Lifetime Maximum for All Covered Services (Network and Non-Network combined)	\$1,000,000
• Substance Abuse	\$ 20,000

NOTE: The Deductible(s) apply only to Covered Services with a percentage Coinsurance amount.

<u>Covered Services</u>	<u>Coinsurance/Maximums</u>	
	<u>Network</u>	<u>Non-Network</u>
Preventive / Wellness Care Child and Adult	Covered in Full	Not Covered
Physician Office Services	20% Coinsurance	30% Coinsurance
Allergy Services - testing and treatment - serum and injections	20% Coinsurance	30% Coinsurance
Inpatient Services	20% Coinsurance	30% Coinsurance
Maximum days per Benefit Period for Physical Medicine and Rehabilitation	Unlimited	
Maximum days per Benefit Period for Skilled Nursing Care Facility Services	Unlimited	
Outpatient Facility Services	20% Coinsurance	30% Coinsurance

Covered Services	Coinsurance/Maximums	
	Network	Non-Network
Therapy Services (when rendered as Physician's Office Services or Outpatient Facility Services	20% Coinsurance	30% Coinsurance

NOTE: If different types of Therapy Services are performed during one Physician Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Spinal Manipulation service are performed during one Physician Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Spinal Manipulation Visit.

Maximum Visits per Benefit Period for:		
Physical & Occupational Therapy	Unlimited	
Speech Therapy	Unlimited	
Chiro / Spinal Manipulations	\$500 per Benefit Period Maximum	
Other Therapy Services (when rendered as Physician's Office Services or Outpatient Facility Services)	20% Coinsurance	30% Coinsurance
Diagnostic Services		
Office / Independent Lab	Covered in Full	30% Coinsurance
Outpatient	20% Coinsurance	30% Coinsurance
TMJ Services	20% Coinsurance	30% Coinsurance
	\$1,000 Lifetime Maximum	

<u>Covered Services</u>	<u>Coinsurance/Maximums</u>	
	Network	Non-Network
Emergency Room Services	20% Coinsurance	30% Coinsurance
Urgent Care Center Services	20% Coinsurance	30% Coinsurance
Ambulance Services	20% Coinsurance	30% Coinsurance
Home Care Services	20% Coinsurance	30% Coinsurance
Maximum Visits per Benefit Period	Unlimited	
Hospice Services	20% Coinsurance	30% Coinsurance
Bereavement Counseling	50% Coinsurance	50% Coinsurance
Maximum Visits per any 6-month period	15 visits	
Lifetime Maximum	15 visits	
Medical Supplies, Durable Medical Equipment and Appliances	20% Coinsurance	30% Coinsurance
Maximum	Rental cost up to the purchase price	

Covered Services	Coinsurance/Maximums	
	Network	Non-Network
Maternity Services		
Inpatient Services	20% Coinsurance	30% Coinsurance
Outpatient Services	20% Coinsurance	30% Coinsurance
Physician Office Services	20% Coinsurance (Global fee applies, no additional Coinsurance applies after the initial office visit)	30% Coinsurance (Global fee applies, no additional Coinsurance applies after the initial office visit)
Mental Health Services		
Inpatient Services	20% Coinsurance	30% Coinsurance
Maximum days per Benefit Period	30 days	
Outpatient/Physician Services	50% Coinsurance	50% Coinsurance
Maximum visits per Benefit Period	25 visits	

Substance Abuse Services		
Lifetime Maximum	2 Inpatient and Outpatient Substance Abuse rehabilitation programs Day/Night Care (counts 2 for 1 against Inpatient days)	
Inpatient Services	20% Coinsurance	30% Coinsurance
Maximum days per Benefit Period	30 days or \$10,000, whichever comes first	
Lifetime Maximum	\$20,000 combined both Inpatient and Outpatient/Physician Office Services	
Outpatient/Physician Services	50% Coinsurance	50% Coinsurance
Maximum visits per Benefit Period	25 visits or \$10,000, whichever comes first	
Lifetime Maximum	\$20,000 combined both Inpatient and Outpatient/Physician Office Services	

<u>Covered Services</u>	<u>Coinsurance/Maximums</u>	
	<u>Network</u>	<u>Non-Network</u>
Human Organ and Tissue Transplant Services		
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).	
Transplants at a Non-Network Facility do not count towards the Out-of-Pocket maximum.		
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 shown below for the actual Covered Transplant Procedure. This amount will accrue to the \$1,000,000 Lifetime Maximum.		
	NETWORK TRANSPLANT FACILITY	NON-NETWORK TRANSPLANT FACILITY
Transplant Services and Procedures With respect to the type of Covered Transplant Procedure performed:	Covered in Full	The lesser of 50% of billed charges, or, 50% of the Maximum Allowable Amount shown in the schedule below. 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.
Adult Procedures		Charge Maximum

<u>(Includes organ /tissue acquisition)</u>	
Adult Heart	\$68,800
Adult Lung	\$97,000
Adult Heart/Lung	\$133,600
Adult Liver	\$97,600
Adult Pancreas	\$75,200
Kidney/Pancreas	\$75,200
Adult Autologous Bone Marrow including High Dose Chemotherapy	\$56,000
Adult Related allogeneic Bone Marrow including High Dose Chemotherapy	\$80,000
Adult Unrelated allogeneic Bone Marrow including High Dose Chemotherapy	\$88,000

Pediatric Procedures	Charge Maximum
<u>(Includes Organ/Tissue Acquisition)</u>	
Pediatric Autologous Bone Marrow including High Dose Chemotherapy	\$66,400
Pediatric Related Allogeneic Bone Marrow including High Dose Chemotherapy	\$93,600
Pediatric Unrelated Allogeneic Bone Marrow including High Dose Chemotherapy	\$115,200
Pediatric Heart	\$104,000
Pediatric Liver	\$106,400

	NETWORK TRANSPLANT FACILITY	NON-NETWORK TRANSPLANT FACILITY
Transportation Lodging and Meals	Covered in Full	50% Coinsurance subject to Deductible
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.		

Prescription Drugs		
Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.		
Retail Pharmacy (Network and Non-Network)	30	
Mail Service	90	
<u>Covered Services</u>	<u>Coinsurance/Maximums</u>	
	Network	Non-Network
Generic Formulary Drugs	20% Coinsurance per Prescription Order	30% Coinsurance per Prescription Order
Generic Non-Formulary Drugs	20% Coinsurance per Prescription Order	30% Coinsurance per Prescription Order
Brand Name Formulary Drugs	20% Coinsurance per Prescription Order	30% Coinsurance per Prescription Order
Brand Name Non-Formulary Drugs	20% Coinsurance per Prescription Order	30% Coinsurance per Prescription Order
NOTE: No Coinsurance applies to certain diabetic and asthmatic supplies, up to Our Maximum Allowable Amount when obtained from a Network Pharmacy. These supplies are covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Network Pharmacy. Diabetic test strips are covered subject to Prescription Drug Coinsurance.		

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 Administrator and the Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health Plan.

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

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 - 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 Administrator, on behalf of the Employer, to be paid at the Network level.

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.

Brand Name Drug - The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met, any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical name (Generic).

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 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 Administrator, on behalf of the Employer, including necessary acquisition costs and preparatory myeloblastic 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 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 Administrator or the Administrator's designee, on behalf of the Employer, determines in its sole discretion to be Experimental/Investigative. The Administrator, on behalf of the Employer, will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Administrator, on behalf of the Employer, 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 Administrator, on behalf of the Employer. In determining whether a Service is Experimental/Investigative, the Administrator, on behalf of the Employer, 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 Administrator, on behalf of the Employer, 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.

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.

Formulary - The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

Generic Drugs - Drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicate those of a Brand Name Drug and is its bioequivalent, Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

Identification Card - A card issued by the 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.

Lifetime Maximum - The maximum dollar amount for Covered Services paid by the Plan during your lifetime.

Mail Service - A prescription drug program which offers a convenient means of obtaining maintenance medications by mail if the Member takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Pharmacy Mail Service, which has entered into a reimbursement agreement with the Administrator, on behalf of the Employer, and sent directly to the Member's home.

Maximum Allowable Amount - The amount that the Administrator or the Administrator's Subcontractor determines, on behalf of the Employer, is the maximum payable for Covered Services you receive, up to but not to exceed charges actually billed. Generally, to determine the Maximum Allowable Amount for a Covered Service, the Administrator or the Administrator's Subcontractor use internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with the Administrator, on behalf of the Employer, for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for the Plan.

For a Non-Network Provider which is a facility, the Maximum Allowable Amount is equal to an amount negotiated with that Non-Network Provider facility for Covered Services under this product or any other product. In the absence of a negotiated amount, the Administrator shall have discretionary authority to establish as the Administrator deems appropriate, the Maximum Allowable Amount for a Non-Network Provider facility. The Maximum Allowable Amount is the lesser of the Non-Network Provider facility's charge, or an amount determined by the Administrator, after consideration of any one or more of the following: industry cost, peer reimbursement, utilization data, previously negotiated rates, outstanding offers that the Administrator may have made, or other factors the Administrator, on behalf of the Employer, deems appropriate. It is your obligation to pay any Deductibles and percentage Coinsurance amounts and any amounts which exceed the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with the Administrator.

Medically Necessary or Medical Necessity - Health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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.”

Mental Health Conditions (including Substance Abuse) - A condition identified as a mental disorder in the most current version of the International Classification of Diseases, in the chapter titled “Mental Disorders”.

- **Mental Health** is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical causes.
- **Substance Abuse** is a condition brought about when an individual uses alcohol or other drug(s) in such a manner that his or her health is impaired and/or ability to control actions is lost.

In determining whether or not a particular condition is a Mental Health Condition, the Plan may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by the Administrator, or with another organization, which has an agreement with the 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 Administrator, on behalf of the Employer, or with another organization, which has an agreement with the 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 Administrator, on behalf of the Employer, or is not otherwise engaged by Administrator, on behalf of the Employer, for the network associated with this Plan. Providers who have not contracted or affiliated with 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 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.

Pharmacy and Therapeutics Committee - a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

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

Pre-Existing Condition - A condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on your Enrollment Date. Pregnancy and domestic violence are not considered Pre-Existing Conditions. Genetic information may not be used as a condition in the absence of a diagnosis.

Prescription Legend Drug - A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, “Caution: Federal law prohibits dispensing without a prescription.” Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Plan.

Prescription Order - A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Prior Authorization -The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

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 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
 5. 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. provide 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.

- **Pharmacy** - An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **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.

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.

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.

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 Administrator and/or Employer may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and Mental Health/behavioral health and Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Administrator's 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 Administrator, on behalf of the Employer.

Temporomandibular or Craniomandibular Joint disorder (TMJ)

Temporalmandibular Joint (TMJ) /Temporomandibular disorder (TMD). The temporalmandibular joint is a complicated joint formed where the lower jaw bone 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.

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. the legal Spouse of the Employee; and
- 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) be unmarried;
 - (ii) be dependent upon the Employee for more than one-half of their annual support;
 - (iii) be less than age 19 or be a Full-Time Student over age 19 but less than age 23 at an accredited College, University or Trade School maintaining at least 12 credit hours of coursework per semester.
- c. a child born to a mother who satisfies the criteria of this Section (3) b., for the first six months of that child's life after the date of birth.

The support requirement as it pertains to a child is waived if the Employee is required to provide coverage due to court order, divorce decree, a Qualified Medical Child Support Order or any other legal decree.

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 19 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.

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.

A Late Enrollee may be subject to a Pre-Existing Condition Exclusion: See the Pre-Existing Condition Exclusion Section of this document.

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.

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 termination 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;
- (2) the date enrollment as a Full-Time Student ends;
- (3) September 1, annually, if enrolled as a Full-Time Student on the last day of the prior Spring term unless the Plan Administrator receives satisfactory confirmation that the dependent will continue studies as a Full-Time Student.
- (4) The date of class graduation following completion of High School, under-graduate or post-graduate study unless the Plan Administrator receives satisfactory confirmation that the dependent will continue studies as a Full-Time Student.

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.

Family and Medical Leave

The Plan shall provide continuation of coverage and eligibility consistent with the provisions of the Family and Medical Leave Act of 1993 (FMLA), as amended. The provisions set forth below shall apply solely with regard to FMLA.

- (1) The FMLA allows certain Employees the right to take an unpaid leave or a paid leave (if it has been earned) for a period of up to twelve (12) work weeks in a twelve (12) month period because of:
 - a. the birth of a child;
 - b. the placement of a child for adoption or foster care;
 - c. the need to care for a family member (child, Spouse or parent) with a serious health condition as defined under the FMLA; or

- d. an Employee's own serious health condition.
- (2) Under the FMLA, an Employee may continue medical coverage under the Plan during the period the Employee is on FMLA leave. The medical coverage is the same as would have been provided if the Employee had been Actively at Work during the leave.
- (3) Employees on FMLA leave are required to continue to pay any required contributions during the FMLA leave. The contributions must be paid to the Employer at the same time as would have been done during Actively at Work employment unless otherwise agreed to in writing by the Employer.

Failure of an Employee to pay required contributions within thirty (30) days after the due date will result in termination of coverage effective on the due date.

Any changes made by the Employer to Employee contributions in general shall apply to an Employee on FMLA leave.

- (4) Termination of coverage under FMLA will occur:
 - a. in accordance with provisions set forth under Termination of Participation in the Eligibility Section;
 - b. when the Employee informs the Employer of the intent not to return from FMLA leave;
 - c. when the Employee fails to return from the FMLA leave; or
 - d. when the maximum duration of FMLA leave occurs.
- (5) The Employee may choose not to continue medical coverage during the FMLA leave, in which case, the Employee shall be immediately allowed to reinstate coverage when the Employee returns from FMLA leave without regard to proof of good health, a new Pre-Existing Condition Exclusion or any Waiting Period set forth in the Plan.

Employees on Military Leave

The Uniformed Services Employment and Reemployment Rights Act mandates certain rights for an Employee and their Dependents covered by the Plan before leaving for military duty to continue coverage when going into or returning from military service:

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - a. The 24-month period beginning on the date on which the absence begins; or
 - b. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102%

of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the share of the Employee, if any, for the coverage.

- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

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 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 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 Administrator. The 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 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 Deductibles and/or percentage Coinsurance amounts.** 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 Administrator, on behalf of the Employer, to be sure that Prior Authorization and/or pre-certification 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:

- obtaining any Precertification which is required;
- filing claims; and
- higher cost sharing amounts.

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

Relationship of Parties (Administrator - Network Providers)

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

The 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 Administrator.

Not Liable for Provider Acts or Omissions

The 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 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

Health Care Management is included in your health care benefits to encourage you to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by assuring the use of appropriate procedures, setting (place of service), and resources through Case Management and through Precertification review requirements which may be conducted either prospectively (Prospective Review), concurrently (Concurrent Review), or retrospectively (Retrospective Review).

If you have any questions regarding Health Care Management or to determine which services require Pre-certification, call the Pre-certification telephone number on the back of your Identification Card or refer to the Administrator's web site, www.anthem.com.

Members are entitled to receive upon request and free of charge reasonable access to and copies of documents, records, and other information relevant to the Member's Precertification request.

Your right to benefits for Covered Services provided under the Plan is subject to certain policies, guidelines and limitations, including, but not limited to, the Administrator's medical policy and Clinical Guidelines.

A description of each Health Care Management feature, its purpose, requirements and effects on benefits is provided in this section.

Clinical Guidelines

The Administrator, on behalf of the Employer, uses clinical guidelines to assist in the interpretation of Medical Necessity. The clinical guidelines include the Administrator's Corporate medical policy, nationally recognized utilization review guidelines, Administrator developed Medical Review/Utilization Review Criteria, Medicare Guidelines, and other decision support material. However, the Benefit Booklet takes precedence over the clinical guidelines. Medical technology and standards of care are constantly changing and the Administrator, on behalf of the Employer, reserves the right to review and update the clinical guidelines periodically.

Precertification

NOTICE: Precertification does NOT guarantee coverage for or the payment of the service or procedure reviewed.

Precertification is a Health Care Management feature which requires that an approval be obtained from the Administrator, on behalf of the Employer, before incurring expenses for certain Covered Services. The Plan's procedures and timeframes for making decisions for Precertification requests differ depending on when the request is received and the type of service that is the subject of the Precertification request.

Urgent Review means a review of medical care or treatment 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 based on a prudent layperson's judgment, or, in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without such care or treatment. Applying the prudent layperson standard, the Administrator, on behalf of the Employer, may determine that an Urgent Review should be conducted. Concurrent Reviews of continued Hospital stays will always be considered urgent.

When care is evaluated, both Medical Necessity and appropriate length of stay for Inpatient admissions will be determined. Medical Necessity includes a review of both the services and the setting. **For certain services, you will be required to use the Provider designated by the Administrator's Health Care Management staff.** The care will be covered according to your benefits for the number of days approved unless the Administrator's Concurrent Review determines that the number of days should be revised. If a request is denied, the Provider may request a reconsideration. The Administrator's Physician reviewer will be available by telephone for the reconsideration within one business day of the request. An expedited reconsideration may be requested when the Member's health requires an earlier decision.

Generally, the ordering Provider, facility or attending Physician may call to request a Precertification review ("requesting provider"). The Administrator, on behalf of the Employer, will work directly with the requesting Provider for the Precertification request. However, You may designate an authorized representative to act on your behalf for a specific Precertification request. The authorized representative can be anyone who is 18 years or older. For Urgent Reviews as defined above, the requesting Provider will be presumed to be acting as your authorized representative. For more information on the Plan's process for designating an authorized representative, call the **Precertification telephone number** on the back of your Identification Card.

It is your responsibility to obtain Precertification. You should verify that the Provider obtains the required Precertification or obtain the required Precertification yourself. If you do not obtain any required Precertification, you are responsible for all charges for services the Administrator, on behalf of the Employer, determines are not Medically Necessary and **a non-compliance penalty of \$300. If you do not obtain the required Precertification, a Retrospective Review will be done to determine if your care was Medically Necessary. You are responsible for all charges for services the Administrator, on behalf of the Employer, determines are not Medically Necessary.**

You are responsible for obtaining Precertification for the following services:

Inpatient admissions to Hospitals and other covered facilities (Skilled Nursing Facility, and rehabilitation facility) except for Emergency admissions and Maternity admissions which result in childbirth (including admissions of forty-eight (48) hours for normal delivery and ninety-six (96) hours for C-section delivery);

Inpatient Admission:

- Elective Admissions
- Emergency Admissions (require Plan notification within 24 hours)
- OB Related Medical Stay(OB complications, Excludes childbirth)
- Newborn Stays beyond Mother
- Inpatient Skilled Nursing Facility
- Rehabilitation facility admissions

Outpatient Services:

- UPPP surgery
- Plastic/Reconstructive surgeries: (only specific procedures listed)
 - Blepharoplasty
 - Rhinoplasty
 - Hairplasty
 - Panniculectomy and Lipectomy/Diatasis Recti Repair
 - Insertion/Injection of Prosthetic Material Collagen Implants
 - Chin Implant/Mentoplasty/Osteoplasty Mandible
- DME/Prosthetics: recommendation is to verify benefits for all DME, and medical necessity on the list below.
 - Wheelchairs; special size, motorized or powered, and accessories
 - Hospital Beds, Rocking Beds, and Air Beds
 - Electronic or externally powered prosthetics
 - Custom made Orthotics and braces
- PET
- Private Duty Nurse services in the home setting.

Human Organ and Bone Marrow/Stem Cell Transplants

All Inpatient admits for the following:

- Heart transplant
- Liver transplant
- Lung or double lung transplant
- Simultaneous Pancreas./Kidney
- Pancreas transplant
- Kidney transplant
- Small bowel transplant
- Multi-visceral transplant
- Stem cell/Bone Marrow transplant (with or without myeloablative therapy)

All Outpatient services for the following:

- Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
- Donor Leukocyte Infusion

Mental Health/Substance Abuse (MHSA):

If Anthem is selected to perform UM, only Inpatient MH/SA admissions will require authorizations.

Referrals:

Out of Network Referrals (may be pre-authorized, based on network availability and or medical necessity.)

For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify the Administrator, on behalf of the Employer, or verify that your physician has notified the Administrator, on behalf of the Employer, of your admission within 48 hours or as soon as possible within a reasonable period of time. When the Administrator, on behalf of the Employer, is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Administrator, on behalf of the Employer, you may avoid financial responsibility for any Inpatient care which is determined to be not Medically Necessary under your health benefit Plan. If your provider does not have a participation agreement with the Administrator, or is a Blue Card provider, you will be financially responsible for any care the Administrator, on behalf of the Employer, determines is not Medically Necessary.

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.

Precertification Procedures

Prospective Review means a review of a request for Precertification that is conducted prior to a Member's Hospital admission or course of treatment. For Prospective Reviews, a decision will be made and telephone notice of the decision will be provided to the requesting provider, as soon as possible, taking into account the medical circumstances, but not later than two business days from the time the request is received by the Administrator, on behalf of the Employer.

For Urgent reviews, telephone notice will be provided to the requesting provider as soon as possible taking into account the medical urgency of the situation, but not later than two calendar days from the time the request is received by the Administrator, on behalf of the Employer.

If additional information is needed to certify benefits for services, the Administrator, on behalf of the Employer, will notify the requesting Provider by telephone and send written notification to you or your authorized representative and the requesting provider of the specific information necessary to complete the review as soon as possible, but not later than two business days after receipt of the request. For Urgent Reviews the Administrator, on behalf of the Employer, will notify the requesting provider by of the specific information necessary to complete the review within 24 hours after receipt of the request by the Administrator. Written notice will be sent following the request by telephone.

The requested information must be provided to the Administrator, on behalf of the Employer, within 45 calendar days from receipt of the Administrator's request. **Note:** If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. For Urgent Reviews, the requested information must be provided within 48 hours after the Administrator's request for specific information.

A decision will be made and telephone notice of the decision will be provided to the requesting provider as soon as possible, but not later than two business days (two calendar days for Urgent Reviews) after the Administrator's receipt of the requested information.

If a response to the Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Administrator's possession and telephone notice of the decision will be provided to the requesting provider not later than two business days (two calendar days for Urgent Reviews) after the expiration of the period to submit the requested information.

Written notice of Prospective Review decisions will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

Concurrent Review

Concurrent Review means a review of a request for Precertification that is conducted during a Member's Inpatient Hospital stay or course of treatment. As a result of Concurrent Review, additional benefits may be approved for care which exceeds the benefit(s) originally authorized by the Administrator's Health Care Management staff, on behalf of the Employer.

If a request for Concurrent Review is received within 24 hours prior to the expiration of the end of the approved care, and it qualifies for Urgent Review, a decision will be made and telephone notice of the decision will be provided to the requesting provider as soon as possible, taking into account the medical urgency of the situation, but not later than 24 hours from the time the request is received by the Administrator, on behalf of the Employer. If the request is not received within 24 hours prior to the end of the approved care, the decision will be made and telephone notice of the decision will be provided to the requesting provider within two calendar days from the time the request is received by the Administrator, on behalf of the Employer. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within one business day of the date the decision is rendered.

For Concurrent Reviews that do not qualify for Urgent Review, the decision will be made and telephone notice will be provided to the requesting provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) within two business days from the time the request is received by the Administrator, on behalf of the Employer. If additional information is needed to certify benefits for services for a Concurrent Review that does not qualify for Urgent review, the Administrator, on behalf of the Employer, will notify the requesting provider by telephone and will send written notice to you or your authorized representative and the requesting provider of the specific information necessary to complete the review within two business days after receipt of the request.

You or your authorized representative and the requesting provider have 45 calendar days from receipt of the Administrator's request to provide the information to the Administrator, on behalf of the Employer. Note: If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day. A decision will be made and telephone notice of the decision will be provided to the requesting provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) within two business days from the time the requested information is received by the Administrator, on behalf of the Employer. If a response to the Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Administrator's possession and telephone notice of the decision will be provided to the requesting provider and written notice of the decision will be sent to you or your authorized representative and the Provider(s) not later than two business days after expiration of the period to submit the requested information.

The Administrator, on behalf of the Employer, will not reduce or terminate a **previously approved** on-going course of treatment until you or your authorized representative receive telephone notice of the Administrator's decision and have an opportunity to appeal the decision and receive notice of the appeal decision.

Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after health care services have been provided to a Member. If Precertification is required but not obtained prior to the service being rendered, the Administrator, on behalf of the Employer, will conduct a Retrospective Review. Further, if a service is subject to a clinical guideline, but precertification is not required for that service, the Administrator, on behalf of the Employer, may conduct a Retrospective Review.

Retrospective review may be completed before a claim is submitted (pre-claim) or after a claim is submitted (post-claim). It does not include a post-claim review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

For Pre-claim Retrospective review, a decision will be made and notice will be provided to you or your authorized representative and the Provider(s) within 2 business days from the time the request is received by the Administrator, on behalf of the Employer. If additional information is needed to certify benefits for services, the Administrator, on behalf of the Employer, will notify you or your authorized representative and the requesting provider in writing of the specific information necessary to complete the review within 2 business days after receipt of the request.

You or your authorized representative and the requesting provider have 45 calendar days from receipt of the Administrator's request to provide the information to the Administrator, on behalf of the Employer. **Note:** If the 45th day falls on a weekend or holiday, the time frame for submission is extended to the next business day.

A decision will be made and notice will be provided to you or your authorized representative and the Provider(s) within 2 business days from the time the requested information is received by the Administrator, on behalf of the Employer. If a response to the Administrator's request for specific information is not received or is not complete, a decision will be made based upon the information in the Administrator's possession and notice will be provided to you and your authorized representative and the Provider(s) not later than 2 business days after expiration of the period to submit the requested information.

For Post-claim Retrospective review, a decision will be made within 30 calendar days from the time the claim is received by the Administrator, on behalf of the Employer. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 30 calendar days from the time the claim is received by the Administrator, on behalf of the Employer.

If additional information is needed to certify benefits for services, the Administrator, on behalf of the Employer, will notify you or your authorized representative and the requesting provider in writing of the specific information necessary to complete the review within 30 calendar days after receipt of the claim.

You or your authorized representative and the requesting Provider have a reasonable amount of time taking into account the circumstances, but not less than forty-five calendar days from the date of the Administrator's request to provide the additional information to the Administrator, on behalf of the Employer. A decision will be made within 15 calendar days from the time the requested information is received by the Administrator, on behalf of the Employer. Written notice of the decision will be provided to you or your authorized representative and the Provider(s) within five business days of the date the decision is rendered, but not later than 15 calendar days of receiving the requested information.

Case Management (includes Discharge Planning)

Case Management is a Health Care Management feature designed to assure that your care is provided in the most appropriate and cost effective care setting. This feature allows the Administrator, on behalf of the Employer; to customize your benefits by approving otherwise non-Covered Services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by the Administrator's Health Care Management staff, on behalf of the Employer. In managing your care, the Administrator, on behalf of the Employer, has the right to authorize substitution of Outpatient Services or services in your home to the extent that benefits are still available for Inpatient Services.

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 Deductible or percentage Coinsurance amount. The 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 Administrator, on behalf of the Employer, bases its decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on the Administrator's medical policy and Clinical Guidelines. The 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 Deductible, percentage Coinsurance amount, Benefit Period maximum, or Lifetime 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 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. Adult routine physical examinations.
 4. Pelvic examinations.
 5. Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.
 6. Annual dilated eye examination for diabetic retinopathy.
 7. 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. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts;
 2. Routine hearing screening.
 3. Routine screening mammograms; 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;
 4. Routine cytologic and chlamydia screening (including pap test);
 5. Routine bone density testing for women;
 6. Routine prostate specific antigen testing;
 7. 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 **Mental Health/Substance Abuse Services** 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** and **Mental Health/Substance Abuse 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 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 or Mental Health/Substance Abuse 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 (including Emergency Room Services)

Medically Necessary Services which the Administrator, on behalf of the Employer, determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. If you contact your Physician and are referred to a Hospital Emergency room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify the Administrator, on behalf of the Employer, or verify that your physician has notified the Administrator, on behalf of the Employer, of your admission within 48 hours or as soon as possible within a reasonable period of time. When the Administrator, on behalf of the Employer, is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Administrator, on behalf of the Employer, you may avoid financial responsibility for any Inpatient care which is determined to be not Medically Necessary under your health benefit Plan. If your Provider does not have a participation agreement with the Administrator, on behalf of the Employer, or is a Blue Card provider, you will be financially responsible for any care the Administrator, on behalf of the Employer, determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as Non-Network unless the Administrator, on behalf of the Employer, authorizes the continuation of care and it is Medically Necessary.

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 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

Ambulance Services are transportation by a vehicle designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals (other vehicles which do not meet this definition, including but not limited to Ambulettes, are not Covered Services):

- from your home, scene of accident or medical Emergency to a Hospital;
- between Hospitals;
- between Hospital and Skilled Nursing Facility;
- from a Hospital or Skilled Nursing Facility to your home.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an Employer, school, fire, or public safety official and the Member is not in a position to refuse.
- When a Member is required by the Administrator, on behalf of the Employer, to move from a non-Network Provider to a Network Provider.

Trips must be to the closest local facility that can give Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

- a Physician's office or clinic;
- a morgue or funeral home.

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 Administrator for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Temporomandibular or Craniomandibular Joint disorder (TMJ)

For Temporomandibular or Craniomandibular Joint disorder and Craniomandibular, jaw disorder regardless of Medical Necessity; with the exception of 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 patients 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 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, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

Hospice care may be provided in the home or Hospice for medical, social and psychological services used as palliative treatment for patients with a terminal illness and includes routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.

Covered Services include the following only when authorized by your Network Provider:

- Skilled Nursing Services (by an R.N. or L.P.N.);
- Diagnostic Services;
- Physical, speech and inhalation therapies;
- Medical supplies, equipment and appliances;
- Counseling services (except bereavement counseling);
- Inpatient confinement at a Hospice;
- Prescription Drugs obtained from the Hospice.

Human Organ and Tissue Transplant Services

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.

Covered Transplant Procedure

Any Medically Necessary human organ and tissue transplant as determined by the Administrator, on behalf of the Employer, including necessary acquisition costs and preparatory myeloblastic 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.

Notification

The Plan strongly encourages the Member to call the Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. The 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 364 days. If, within this time frame, a second Covered Transplant Procedure occurs, the Covered Transplant Benefit Period will begin one day prior to the second Covered Transplant Procedure and continue for 364 days.

Transportation, Meals and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the 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, lodging and meals for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging and meals may be allowed for two companions. The Member must submit itemized receipts for transportation, meals, and lodging expenses in a form satisfactory to the Administrator when claims are filed. Contact the Administrator for detailed information.

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, including but not limited to, Depo-Provera.
- **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 homograft 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

Outpatient Services, Physician Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are 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 patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- oral examinations;
- x-rays;
- tests and laboratory examinations;
- restorations;
- prosthetic services;
- oral surgery;
- mandibular/maxillary reconstruction;
- anesthesia.

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.

Mental Health/Substance Abuse Services

Covered Services include but are not limited to:

- **Inpatient services** – individual or group psychotherapy, psychological testing, family counseling with family Members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy. Room and board charges are Covered Services only when an Inpatient stay is authorized by the Administrator or the Administrator's Subcontractor.
- **Partial hospitalization** - a structured, intensive, multidisciplinary treatment program that provides psychiatric, medical, and nursing care. The program usually is offered in an acute setting, but the patient goes home in the evening and on weekends. The program delivers a highly structured environment of at least 4 to 6 hours of treatment per day. Patients are expected to participate up to 5 days per week.
- **Intensive Outpatient treatment or day treatment** - a structured program, offered at least 3 times per week for at least 3 hours per day. The program may be managed by a licensed Mental Health professional with a psychiatrist on staff. Therapy is provided by a licensed Mental Health professional.
- **Outpatient treatment, or individual or group treatment** - office-based services, for example diagnostic evaluation, counseling, psychotherapy, and medication evaluation. The service may be provided by a licensed Mental Health professional and is coordinated with the psychiatrist.

Two days of partial hospitalization treatment or intensive Outpatient treatment are the equivalent of one day as an Inpatient.

Non-Covered Mental Health/Substance Abuse Services:

- Residential Treatment services. Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
- Custodial or Domiciliary care.
- Supervised living or half-way houses.
- Room and board charges unless the treatment provided meets the Administrator's Medical Necessity criteria for Inpatient admission for your condition.

Prescription Drug Benefits

See the Schedule of Benefits for any applicable Deductible, Coinsurance and Benefit Limitation information.

Pharmacy Benefits Manager

The pharmacy benefits available to you under this Plan is managed by Our Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which the Administrator, on behalf of the Employer, contracts to manage your pharmacy benefits. -The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating, the covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies and operating a Mail Service pharmacy. The PBM, in consultation with the Administrator, on behalf of the Employer, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Customer Service telephone number on the back of your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Administrator, on behalf of the Employer, can determine Medical Necessity. The Administrator, on behalf of the Employer, may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs. Covered Services will be limited based on Medical Necessity, quantity, and/or age limits established by the Administrator, on behalf of the Employer, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system and the pharmacist is instructed to contact the Administrator, on behalf of the Employer, or the PBM. The Administrator, on behalf of the Employer, or the PBM, use pre-approved criteria, developed by Our Pharmacy and Therapeutics Committee and reviewed and adopted by the Administrator, on behalf of the Employer. The Administrator, on behalf of the Employer, or the PBM, communicates the results of the decision to the pharmacist. The Administrator, on behalf of the Employer, or the PBM, may contact your prescribing Physician if additional information is required to determine whether Prior Authorization should be granted.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the Complaint and Appeals Procedure section of this Benefit Booklet.

For a list of the current Drugs requiring Prior Authorization, please contact the Customer Service telephone number on the back of your ID card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage under your Plan. Refer to the Prescription Drug benefit sections in this Benefit Booklet, for information on coverage, limitations, and exclusions. Please ask your Provider or Network pharmacist to check with the Administrator, on behalf of the Employer, or with the PBM to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Plan.

Therapeutic Substitution of Drugs is a program approved by Administrator, on behalf of the Employer, and managed by the PBM. This is a voluntary program designed to inform Members and Physicians about possible alternatives to certain prescribed Drugs. The Administrator, on behalf of the Employer, or the PBM, may contact you and your prescribing Physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic Drug substitutes, contact us by calling the Customer Service telephone number on the back of your ID card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

Step Therapy

Step therapy protocol means that a Member may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed, the Physician will need to submit a letter fax including the following details:

- Member name and ID number;
- Diagnosis;
- Drug name;
- Reason for appeal;
- Physician name, specialty, address, and phone number.

Covered Prescription Drug Benefits

- Prescription Legend Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any percentage Coinsurance. Contact Us to determine approved covered supplies. If certain supplies, equipment, or appliances are not obtained by Mail Service or from, a Network Pharmacy then they are covered as Medical Supplies, Equipment, and Appliances instead of under Prescription Drug benefits.
- Injectables.

- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.
- Retin-A is covered up to age 24.
- Renova is covered up to age 24.

Non-Covered Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other non-Covered Services)

- Prescription Drugs dispensed by any Mail Service program other than the Anthem Mail Service, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product.
- Off label use, except as otherwise prohibited by law or as approved by the Plan or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including, but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities which exceed the limits established by the Plan, or which exceed any age limits established by Us.
- 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.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices, or products, they are not Covered Services.
- Drugs in quantities, which exceed the limits established by the Plan.
- Human Growth Hormone for children born small for gestational age. It is only a Covered

Service in other situations when allowed by Us through Prior Authorization.

- Compound Drugs unless there is at least one ingredient that requires a prescription.
- Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products.
- Treatment of Onchomycosis (toenail fungus).
- Contraceptive drugs, including injectable contraceptive drugs and patches.
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact Us for additional information on these Drugs.
- Mifeprex.
- Preven.
- Glocowatch.

Deductible/Coinsurance

Each Prescription Order may be subject to a Deductible and percentage Coinsurance. If the Prescription Order includes more than one covered Drug, a separate percentage Coinsurance will apply to each covered Drug. Your Prescription Drug Coinsurance will be the lesser of your scheduled Coinsurance amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for any applicable Deductible and Coinsurance. If you receive Covered Services from a Non-Network Pharmacy, a Deductible and Coinsurance amount may also apply.

Days Supply

The number of days supply of a Drug, which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits.

Plan Pay Maximum

The maximum We will pay on average for the days allowed at Network Retail Pharmacy.

Generic Drug Encouragement

We may, from time to time, offer incentives to encourage the use of Generic Drugs. This may involve waiving a percentage Coinsurance amount for certain Generic Drugs for a period of time or other incentives.

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, a Non-Network Pharmacy, or the Anthem Mail Service Program. It is also based upon whether you obtain a Generic or Brand Name Prescription Legend Drug **and whether Formulary Prescription Legend Drugs were dispensed. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

Note: The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by Us for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Coinsurance for which you are responsible.

Your Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors. For Covered Services provided by a Network Pharmacy or through the Anthem Mail Service, you are responsible for all Deductibles and/or Coinsurance amounts.

For Covered Services provided by a Non-Network Pharmacy, you will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

Network Pharmacy – Present your written Prescription Order from your Physician and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or percentage Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to Us with a written request for refund.

Non-Network Pharmacy – You are responsible for payment of the entire amount charged by the Non-Network Pharmacy. You must submit a Prescription Drug claim form to Us for reimbursement consideration. These forms are available from Us or from the Group. You must complete the top section of the form and ask the Non-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to Us. The itemized receipt must show:

- name and address of the Non-Network Pharmacy;
- patient's name;
- prescription number;
- date the prescription was filled;
- name of the Drug;
- cost of the prescription;
- quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount as determined by Anthem or the PBM's normal or average contracted rate with network pharmacies on or near the date of service.

Anthem Mail Service – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible and/or percentage Coinsurance amounts to the Mail Service when you request a prescription or refill.

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 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 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 Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you or if Worker's 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, including work release programs, unless otherwise required by law or regulation.
9. For any Pre-Existing Condition for the time period specified in the Schedule of Benefits, subject to the Portability provision of this Benefit Booklet. This Exclusion is not applicable to newborns, adopted children, or children placed for adoption who are enrolled under this Plan within 31 days of the date of birth or placement for adoption.

10. For Prescription Drug Copayments or Deductibles You are responsible for under other coverage with other carriers or health plans.
11. 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.
12. For court ordered testing or care.
13. For which you have no legal obligation to pay in the absence of this or like coverage.
14. 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.
15. Prescribed, ordered, or referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, or self.
16. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
17. For missed or canceled appointments.
18. For mileage costs or other travel expenses, except as authorized by the Administrator, on behalf of the Employer.
19. For those groups who have selected the Medicare Part D Subsidy option and the qualifying retiree enrolls in Medicare Part D. The Group Health Plan coverage could possibly terminate the qualifying retirees Group Health Plan coverage
20. Charges in excess of the Maximum Allowable Amount.
21. Incurred prior to your Effective Date.
22. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
23. 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.

24. 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.
25. For Custodial Care, Domiciliary Care or convalescent care, whether or not recommended or performed by a professional.
26. 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.
27. For any treatment of teeth, gums or tooth related service except as otherwise specified as covered in this Benefit Booklet.
28. 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.
29. For sex transformation surgery and related services, or the reversal thereof.
30. For marital counseling.
31. For Family Therapy.
32. 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.
33. For hearing aids or examinations for prescribing or fitting them.
34. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
35. 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.
36. For personal hygiene and convenience items.
37. For care received in an emergency room, which is not Emergency Care, except as specified in this Benefit Booklet.
38. For expenses incurred at a health spa or similar facility.

39. For self-help training and other forms of non-medical self-care, except as otherwise provided herein.
40. For examinations relating to research screenings.
41. For stand-by charges of a Physician.
42. For physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
43. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy.
44. Related to any mechanical equipment, device, or organ.
45. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility.
46. For Private Duty Nursing Services except when provided through the Home Care Services benefit.
47. 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.
48. 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.
49. 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, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergal synchronization technique (BEST) and iridology-study of the iris.
50. For drugs in quantities, which exceed the limits established by the Plan.
51. For elective or therapeutic abortions.
52. For military service for any country or organization and service with military or paramilitary forces as a civilian.

53. 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.
54. 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.
55. 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.
56. 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.
57. For charges for complications that are the result of or related to treatment or procedures that are ineligible for coverage under this Plan.
58. For charges for treatment of an injury or sickness caused by excessive personal use of alcohol, illegal drugs or abuse of controlled substances as substantiated by an official police report or citation, an attending physician or report by an emergency medical technician, report of a coroner, conviction in a court of law or existence of officially reported evidence of blood levels exceeding maximum tolerance standards established in the jurisdiction of the accident causing such Injury.
59. For medical treatment of the Temporomandibular Joint (TMJ) and other jaw disorders and services directly attributable to TMJ will be limited to the maximum benefit stated in the Schedule of Benefits.
60. For direct treatment to the teeth or periodontium shall be considered dental services and are excluded from the medical portion of this Plan.
61. For birth control medications, injectables or devices.
62. 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.
63. For charges for complications that are the result of or related to treatment or procedures that are ineligible for coverage under this Plan.
64. For Orthotics, unless custom made.
65. For Lasik Eye Surgery.

66. For Self-Inflicted Injuries--only covered by the existence of a medically diagnosed emotional or psych disorder for which the individual had received medical treatment or prescribed medication during the 6-month period immediately preceding the injury or illness.
67. For smoking cessation.
68. Services of a Physician employed by any government unless a charge must be paid by the Participant.
69. Charges for Voluntary Sterilization procedures.

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.

How Benefits Are Paid

The Plan shares the cost of your medical expenses with you up to the amount of the Maximum Allowable Amount. For services subject to a Deductible, you pay a portion of the bill before the Plan begins to pay its share of the balance. Most services are subject to both a Deductible and percentage Coinsurance amount.

Network Providers will seek compensation from the Plan for Covered Services. When using a Network Provider you are only responsible for Deductibles, percentage Coinsurance amounts and non-covered charges. Network Providers have agreed to accept the Maximum Allowable Amount as payment in full. If you receive Covered Services from a Non-Network Provider, you are responsible for the difference between the actual charge billed and the Maximum Allowable Amount plus any Deductible, percentage Coinsurance amounts and non-covered charges. Refer to the Schedule of Benefits to see what Deductibles and percentage Coinsurance amounts are required for each Covered Service.

The amount you pay may differ by the type of service you receive or by Provider. Refer to the Schedule of Benefits to see what amount you are required to pay for each service. Claims for Covered Services do not need to be sent to the Administrator in the same order that expenses were incurred.

If you receive Covered Services in a Network Provider facility from a Non Network Provider such as an anesthesiologist who is employed by or contracted with that Network Facility, benefits will be paid. Payment will not exceed the Maximum Allowable Amount that would constitute payment in full under a Network Provider's participation agreement for this Plan. You may be liable for the difference between the billed charge and the Maximum Allowable Amount. This does not apply if your treating Physician is a Non-Network Provider who performs services at a Network Provider facility.

The Administrator, on behalf of the Employer, will deny that portion of any charge which exceeds the Maximum Allowable Amount.

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 Administrator for more information.

Continuous Coverage

If you were previously covered by a Plan with the Employer and with the 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 Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. The 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 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 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 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 Administrator within 90 days of receiving the Covered Services, and must have the data the Administrator needs to determine benefits. If the notice submitted does not include sufficient data the Administrator needs to process the claim, then the necessary data must be submitted to the Administrator within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If the Administrator has not received the information it needs to process a claim, the 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 Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator generally will make its request for additional information within 30 days of the Administrator's initial receipt of the claim and will complete its processing of the claim within 15 days after the 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 Administrator notice within 90 days 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 90 day 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 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 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 Administrator has not received the information needed to process a claim, the 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 Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator, on behalf of the Employer, generally will make a request for additional information within 30 days of the Administrator or Employer's initial receipt of the claim and will complete processing of the claim within 15 days after the 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 Administrator, on behalf of the Employer, such authorizations, consents, releases, assignments and other documents as may be requested by the Administrator, in order to obtain or assure reimbursement under Medicare, Worker’s 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 payor) will be responsible for any charge for services.

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 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.

BlueCard

When you obtain health care services through BlueCard outside the geographic area the Administrator serves, the amount you pay for Covered Services is calculated on the **lower** of:

- The billed charges for your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes onto the Administrator, on behalf of the Employer.

Often this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price, expected settlements, withholds, any contingent payment arrangements, and non-claims transactions with your health care Provider or with a specified group of Providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over-or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Administrator, on behalf of the Employer, would then calculate your liability for any Covered Services in accordance with the applicable state statutes in effect at the time you received your care.

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.

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 Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Administrator by the Employer, and any and all statements made to the Employer by the 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 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 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 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 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 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 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 Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the 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 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

Applicability

This provision applies when you have health care coverage under more than one Plan. For the purposes of this provision, "Plan" is defined below.

If this provision applies, the Order of Benefit Determination Rules specify whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

1. will not be reduced when, under the Order of Benefit Determination Rules, this Plan determines its benefits before another Plan; but
2. may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The reduction is described under the heading "Effects on the Benefits of this Plan."

Definitions

Plan - this Plan and any other arrangement providing health care or benefits for health care through:

1. group insurance or group-type coverage whether insured or uninsured. This includes prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

2. coverage under a governmental Plan or coverage required or provided by law except Medicare or Medicaid.
3. the medical benefits coverage in-group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts.
4. any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee Plan, a union welfare Plan, an employee organization Plan or an employee benefit organization.
5. any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

“Plan” is not any of the following:

1. Individual or family coverage, including insurance contracts, subscriber contracts, coverage through health maintenance organizations or other prepayment group practice and individual practice plans which are not group coverage.
2. Group or group-type Hospital indemnity benefits of \$100.00 per day or less.
3. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a “to and from” school basis.

Primary Plan/Secondary Plan - the Order of Benefit Determination Rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

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

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Allowable Expense - a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made. The item of expense covered in part by this Plan is subject to the Plan’s Maximum Allowable Amount.

The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an Allowable Expense under the above definition unless the patient’s stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in this Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When the benefits are reduced under a Primary Plan because a Member does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, Precertification of admissions or services, and preferred Provider arrangements. Only benefit reductions based upon provisions similar to this one and which are contained in the primary Plan may be excluded from allowable expenses. This provision shall not be used by a Secondary Plan to refuse to pay benefits because a health maintenance organization (HMO) Member has elected to have health care services provided by a non-HMO provider and the HMO, pursuant to this Benefit Booklet, is not obligated to pay for providing those services.

Allowable Expense does not include any expenses incurred or claims made under the Prescription Drug program of this Plan.

Order of Benefit Determination Rules

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of this Plan; and
2. both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the person as a Subscriber or Member, (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent, except that: if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - a. Secondary to the Plan covering the person as a Dependent; and
 - b. Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee);

then the order of benefits is reversed so that the Plan covering the person as an employee, Member, subscriber or retiree is secondary and the other Plan is primary.

2. Dependent Child/Parents not Separated or Divorced. When this Plan and another Plan cover the same child as a Dependent of parents who are not separated or divorced:

- a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
- b. if both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in a. immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the Plan of the parent with custody of the child;
 - b. Then, the Plan of the spouse of the parent with custody of the child; and
 - c. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the Primary Plan has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent will be the Secondary Plan.

4. **Joint Custody.** If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined in paragraph 2.
5. **Active/Inactive Subscriber.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule 5 is ignored. This rule does not supersede rule 1 above.
6. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

- a. First, the benefits of a Plan covering the person as a Subscriber or Member or as that person's Dependent;
 - b. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
7. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered the person longer are determined before those of the Plan which covered that person for the shorter term.

Effect on this Plan's Benefits

When a Member is covered under two or more Plans which together pay more than the Allowable expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is primary. However, when this Plan is secondary under the Order of Benefit Determination Rules, benefits payable will be reduced, if necessary, so that combined benefits of all Plans covering you or your Dependent do not exceed the Plan's Maximum Allowable Amount for the Allowable Expense.

When this Plan is secondary, you will receive credit during the remainder of the calendar year for the amount by which your benefits are reduced. This credit will not be applied to the extent that would cause you to receive:

1. a combined benefit from all Plans greater than the Allowable Expense; or
2. more benefits during a calendar year than you would receive if there were no other coverage.

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

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. The Administrator, on behalf of the Employer, has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Administrator any facts it needs to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The 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.

Medicare

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, we will calculate benefits as if they had enrolled. For those groups who have selected the Medicare Part D Subsidy option and the qualifying retiree enrolls in Medicare Part D, the Group Health Plan could possibly terminate the qualifying retirees Group Health Plan coverage.

Worker’s Compensation

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Worker’s Compensation Law. All sums paid or payable by Worker’s 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 Worker’s Compensation.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, 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 Plan benefits are paid as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

The Administrator, on behalf of the Employer, has the right to recover Plan payments made on your behalf from any party responsible for compensating you for your injuries. The following apply:

The Administrator, on behalf of the Employer, has the first priority for the full amount of benefits they have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.

- You and your legal representative must do whatever is necessary to enable the Administrator, on behalf of the Employer, to exercise their rights and do nothing to prejudice them.
- The Administrator, on behalf of the Employer, has the right to take whatever legal action they see fit against any 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 Administrator's subrogation claim and any claim still held by you. The Administrator'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 Administrator, on behalf of the Employer, is not responsible for any attorney fees, other expenses or costs without its prior written consent. The Administrator, on behalf of the Employer, further agrees that 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 Administrator, on behalf of the Employer.

Reimbursement

If you obtain a Recovery and the Administrator, on behalf of the Employer, has not been repaid for the benefits the Administrator, on behalf of the Employer, paid on your behalf, the Administrator, on behalf of the Employer, shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse the Administrator, on behalf of the Employer, to the extent of Plan benefits the Administrator, on behalf of the Employer, paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, the Administrator, on behalf of the Employer, shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for the Administrator, on behalf of the

Employer, 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 Administrator, on behalf of the Employer, immediately upon your receipt of the Recovery. You must reimburse the Employer, 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 Administrator, on behalf of the Employer.

-
- If You fail to repay the Administrator, on behalf of the Employer, the Administrator, on behalf of the Employer, shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Administrator, on behalf of the Employer, has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
 1. The amount the Administrator, on behalf of the Employer, paid on your behalf is not repaid or otherwise recovered by the Administrator, on behalf of the Employer; or
 2. You fail to cooperate.
- In the event that You fail to disclose to the Administrator and/or the Employer the amount of your settlement, the Administrator, on behalf of the Employer, shall be entitled to deduct the amount of their lien from any future benefit under the Plan.
- The Administrator, on behalf of the Employer, shall also be entitled to recover any of the unsatisfied portions of the amount they have paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Administrator, on behalf of the Employer, has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Administrator, on behalf of the Employer, would not have any obligation to pay the Provider.

The Administrator, on behalf of the Employer, 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 or make you whole.

Your Duties

- You must notify the Administrator, on behalf of the Employer, 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 Administrator, on behalf of the Employer, in the investigation, settlement and protection of the Employer's rights of the Administrator, on behalf of the Employer.
- You must not do anything to prejudice the rights of the Administrator, on behalf of the Employer.
- You must send the Administrator, on behalf of the Employer, 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 Administrator, on behalf of the Employer, if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

Whenever payment has been made in error, the Administrator, on behalf of the Employer, will have the right to recover such payment from you or, if applicable, the Provider. The 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 Administrator, on behalf of the Employer, has oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. The 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 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 Administrator, on behalf of the Employer, will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The 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-Administrator)

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

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

COMPLAINT AND APPEALS PROCEDURES

The 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 Deductible and 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 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 Administrator's Networks.

The Complaint Procedure

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

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the 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 Administrator can request medical records for its review.

The Appeals Procedure

As a Member of the Plan, you have the right to appeal decisions to deny or limit the Plan benefits. You may also file an appeal to address concerns regarding confidentiality or privacy. Appeals should be filed with the Administrator for review in accordance with the procedures set forth below.

Administrator Appeals

An appeal is a request from you for the Administrator to change a previous determination made. An initial determination by the Administrator can be appealed for further review by the Administrator at two subsequent levels known as “Level 1” and “Level 2” appeals. The Administrator will advise you of your rights to the next level of review if a denial is upheld after a Level 1 appeal or a Level 2 appeal.

You have the right to designate a representative (e.g. your Physician) to file an appeal on your behalf and to represent you in the appeal. If a representative is seeking an appeal on your behalf, the Administrator must obtain a signed Designation of Representation form from you before the Administrator can begin processing your appeal unless a Physician is requesting expedited review of a Level 1 appeal on your behalf. If that occurs, the Physician will be deemed to be your representative for the purpose of filing the expedited Level 1 appeal without receipt of a signed form.

Once an appeal has been filed as described below, the Administrator will accept oral or written comments, documents or other information relating to your appeal from you, your designated representative or your provider by telephone, facsimile or other reasonable means. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to your appeal.

Level 1 Appeals

Level 1 appeals are reviewed by a person who did not make the initial determination and who is not the subordinate of the initial reviewer. If a clinical issue is involved, the Administrator will use a clinical peer for this review unless your appeal concerns an adverse voluntary predetermination decision or unless the adverse decision can be overturned based upon prescreening by a nurse or other qualified reviewer. A clinical peer is a physician or provider who has the same license as the provider who will perform or has performed the service.

If your Level 1 appeal concerns an adverse Precertification decision, your appeal may be initiated by letter or over the phone. The Administrator requires its Members to submit all other requests for appeal in writing. Written appeal requests, including a detailed description of the problem and all relevant information, should be sent to Attention: Appeals; Anthem Blue Cross and Blue Shield; P. O. Box 166; Indianapolis, IN 46206 or to the address (or phone number for adverse Precertification decisions) provided for filing an appeal on any written notice of an adverse decision that you receive from the Administrator.

If you are appealing an adverse Precertification decision (i.e., an adverse Prospective, Concurrent or Prospective Review decision) or the denial of any prior approval required by the Plan, the Administrator will provide you with a written response indicating the Plan's decision within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days of the date the Administrator receives your Level 1 appeal request. If more information is needed to make a decision on your appeal, the Administrator will send a written

request for the information after receipt of the appeal. No extensions of time for additional information may be taken on these Level 1 appeals without the permission of the Member. Therefore, the Administrator will make a decision based upon the available information if the additional information requested is not received.

If you are appealing any other type of adverse decision and sufficient information is available to decide the appeal, the Administrator will resolve your Level 1 appeal within a reasonable period of time but not later than 30 business days from receipt of the Level 1 appeal request. If more information is needed to make a decision on your appeal, the Administrator shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 business days of the Level 1 appeal request, the Administrator shall conduct its review based upon the available information, which review shall be completed within a reasonable period of time but not later than 40 business days from receipt of the Level 1 appeal request. After the Level 1 appeal decision is made, you will be notified within 5 business days in writing by the Administrator of the Plan's decision concerning your Level 1 appeal.

Level 2 Appeals

If you are dissatisfied with the Level 1 appeal decision, you may request a Level 2 appeal. At Level 2, the appeal is reviewed by a panel of the Administrator's staff members. You have a right to personal appearance before the Level 2 appeals panel. Level 2 appeals concerning adverse Precertification decisions or the denial of any prior approval required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Level 2 appeal request was received by the Administrator. All other Level 2 appeals will be resolved by the panel no later than 45 business days from the date your Level 2 appeal request was received by the Administrator. After the appeal panel makes a decision you will be notified within 5 business days in writing by the Administrator of the Plan's decision concerning your Level 2 appeal.

Expedited Reviews

Any level of appeal can be expedited if:

- The service at issue has not been performed;
- The service at issue has been denied as Experimental/Investigative or as not Medically Necessary; and
- Your physician believes that the standard appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

The Administrator by applying a prudent lay person standard may also determine that an appeal may be expedited.

The Administrator will complete expedited review of a Level 1 appeal as soon as possible taking into account the medical urgency of the situation but not later than forty-eight hours (48 hours) after the Administrator receives the Level 1 appeal request and will communicate the Plan's decision by telephone to your attending physician or the ordering provider. The Administrator will also provide written notice of the Plan's determination to you, your attending physician or ordering provider, and the facility rendering the service. The Administrator will complete expedited review of a Level 2 appeal as expeditiously as the medical condition requires and panel administration permits. The Plan's decision will be communicated by telephone to your attending physician or the ordering provider. The Administrator will also provide written notice of the Plan's determination to you, your attending physician or ordering provider, and to the facility rendering the service.

External Appeals

If you are dissatisfied with the Plan's Level 2-appeal decision, an "External Appeal" may be available. External Appeal is available if a service or supply has been denied as Experimental/Investigative. The External Appeal option also extends to services denied as not Medically Necessary if the cost of the medical service is over \$10,000 or if the service at issue has not been received and non-receipt of the medical service would jeopardize the patient's life or health. It is coordinated by the Administrator and involves a review of the case by an independent reviewer. External Appeal is available after all other appeal rights with the Administrator are exhausted. In a case of urgently needed care, the Administrator may elect to bypass some levels of appeal to send a case directly to an External Appeal. An External Appeal is not available for services or supplies that are limited or excluded by contract.

Appeals Filing Time Limit

You are encouraged to file Level 1 appeals on a timely basis. The Administrator will not review a Level 1 appeal if it is received after the end of the calendar year plus 12 months since the incident leading to the Member's appeal. Level 2 appeals must be filed within 60 days of receipt of notice of the Level 1 appeal determination. An External Appeal must be filed within 60 days from receipt of the Plan's Level 2-appeal decision.

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.

