You've made a good decision in choosing Blue Access for Health Savings Account℠

State of Indiana

For more information, visit our web site at anthem.com
01/01/2015 00083795

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
Independent licensee of the Blue Cross and Blue Shield Association.
ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Table of Contents

1 Health Benefit Booklet **M-1**

Administered by Anthem Insurance Companies, Inc.

Anthem BlueCross BlueShield

Administered by Anthem Insurance Companies, Inc.

Your Health Benefit Booklet

Health Benefit Booklet

Blue Access for Health Savings Accounts

Administered by
Anthem Insurance Companies, Inc.

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

ANTHBN-PPO 2015 ASO

1 INTRODUCTION

This Benefit Booklet has been prepared by the Administrator, on behalf of the Employer, to help explain your health benefits. Please read this Benefit Booklet carefully, and refer to it whenever you require medical services.

This Benefit Booklet describes how to get medical care, what health services are covered and not covered, and what portion of the health care costs you will be required to pay. Many of the provisions in this Benefit Booklet are interrelated; therefore, reading just one or two sections may not give you an accurate impression of your coverage. You are responsible for knowing the terms of this Benefit Booklet.

The coverage described in this Benefit Booklet is based upon the conditions of the Administrative Services Agreement issued to your Employer, and is based upon the benefit plan that your Employer chose for you. The Administrative Services Agreement, this Benefit Booklet and any endorsements, amendments or riders attached, form the Administrative Services Agreement under which Covered Services are available under your health care benefits.

Many words used in this Benefit Booklet have special meanings. These words are capitalized. If the word or phrase was not explained in the text where it appears, it may be defined in the "Definitions" section. Refer to these definitions for the best understanding of what is being stated.

If you have any questions about this Benefit Booklet, please call the member service number located on the back of your Identification (ID) Card or visit www.anthem.com. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

2 FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

Choice of Primary Care Physician

The Plan generally allows the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in the Administrator's Network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification card or refer to the Administrator's website, www.anthem.com. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

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

3 YOUR RIGHTS AND RESPONSIBILITIES AS AN ANTHEM BLUE CROSS BLUE SHIELD MEMBER

As an Anthem Blue Cross Blue Shield (Anthem) Member you have certain rights and responsibilities to help make sure that you get the most from your Plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and Federal laws, and privacy rules.
- Get information about Anthem's company and services, and Anthem's network of doctors and other health care Providers.
- Get more information about your rights and responsibilities and give Anthem your thoughts and ideas about them.
- Give Anthem your thoughts and ideas about any of the rules of your health care plan and in the way your Plan works.
- Make a complaint or file an appeal about:
    - Your health care Plan
    - Any care you get
    - Any Covered Service or benefit ruling that your health care Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the Anthem's policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.

You have the responsibility to:

- Choose any Primary Care Physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care Plan rules and policies.
- Let Anthem's Customer Service department know if you have any changes to your name, address or family members covered under your Plan.
- Give Anthem, the Employer, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with the Employer.

For details about your coverage and benefits, please read your Benefit Booklet.

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

Contents

1 INTRODUCTION M-3
2 FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES M-4
Choice of Primary Care Physician M-4
Access to Obstetrical and Gynecological (ObGyn) Care M-4
3 YOUR RIGHTS AND RESPONSIBILITIES AS AN ANTHEM BLUE CROSS BLUE SHIELD MEMBER M-5
4 SCHEDULE OF BENEFITS M-9
5 COVERED SERVICES M-17
Ambulance Services M-18
Autism Spectrum Disorder Services M-19
Behavioral Health Services M-19
Clinical Trials M-20
Dental Services M-21
Diabetic Equipment, Education and Supplies M-22
Diagnostic Services M-22
Emergency Care and Urgent Care Services M-24
Home Care Services M-25
Hospice Services M-26
Inpatient Services M-27
Maternity Services M-28
Medical Supplies, Durable Medical Equipment, and Appliances M-30
Outpatient Services M-34
Physician Home Visits and Office Services M-35
Preventive Care Services M-35
Surgical Services M-37
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder M-39
Therapy Services M-39
Human Organ and Tissue Transplant Services M-41
6 NON-COVERED SERVICES/EXCLUSIONS M-42
7 ELIGIBILITY AND ENROLLMENT M-48
Eligibility M-49
8 CHANGES IN COVERAGE: TERMINATION, CONTINUATION & CONVERSION M-53
Individual Termination M-53
Continuation M-53
Family and Medical Leave Act of 1993 . . . . . M-58
9 HOW TO OBTAIN COVERED SERVICES M-58
Network Services and Benefits M-58
Non-Network Services M-60
Relationship of Parties (Plan - Network Providers) M-60
Not Liable for Provider Acts or Omissions M-60
Identification Card M-61
10 CLAIMS PAYMENT M-61
How Benefits Are Paid M-61
Claims Review M-65

Payment of Benefits . . . M-65
Notice of Claim . . . M-65
Time Benefits Payable . . . M-66
Claim Forms . . . M-66
Member's Cooperation . . . M-67
Explanation of Benefits (EOB) . . . M-67
Inter-Plan Programs . . . M-67
11 HEALTH CARE MANAGEMENT . . . M-70
HEALTH PLAN INDIVIDUAL CASE MANAGEMENT . . . M-73
Voluntary Clinical Quality Programs . . . M-74
Value-Added Programs . . . M-74
12 YOUR RIGHT TO APPEAL . . . M-75
Notice of Adverse Benefit Determination . . . M-75
Appeals . . . M-76
How Your Appeal will be Decided . . . M-77
Notification of the Outcome of the Appeal . . . M-77
Appeal Denial . . . M-77
Voluntary Second Level Appeals . . . M-78
External Review . . . M-78
Requirement to file an Appeal before filing a lawsuit . . . M-79
13 GENERAL PROVISIONS . . . M-79
Entire Contract . . . M-79
Form or Content of Benefit Booklet . . . M-79
Disagreement with Recommended Treatment . . . M-79
Circumstances Beyond the Control of the Plan . . . M-80
Protected Health Information Under HIPAA . . . M-80
Coordination Of Benefits . . . M-80
Medicare . . . M-85
Physical Examination . . . M-85
Workers' Compensation . . . M-85
Other Government Programs . . . M-86
Subrogation and Reimbursement . . . M-86
Right of Recovery . . . M-87
Relationship of Parties (Employer-Member Plan) . . . M-88
Anthem Blue Cross and Blue Shield Note . . . M-88
Conformity with Law . . . M-88
Clerical Error . . . M-88
Policies and Procedures . . . M-89
Medical Policy and Technology Assessment . . . M-89
Waiver . . . M-89
Employer's Sole Discretion . . . M-89
Reservation of Discretionary Authority . . . M-89
14 DEFINITIONS . . . M-90
15 FOR QUESTIONS ABOUT BENEFITS, CLAIMS, ENROLLMENT, OR BILLINGS . . . M-99

4 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copayments, maximums and other limits that apply when you receive Covered Services from a Provider. Please refer to the "Covered Services" section of this Benefit Booklet for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any endorsements, amendments, or riders.

This Schedule of Benefits lists the Member's responsibility for Covered Services.

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use a Non-Network Provider you are responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges.

Copayments/Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

Essential Health Benefits provided under this Plan are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or annual dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**
- **Mental health and substance use disorder services, including behavioral health treatment,**
- **Prescription drugs,**
- **Rehabilitative and habilitative services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**
- **Chronic disease management and pediatric services, including oral and vision care.**

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

BENEFIT PERIOD	Calendar Year

DEPENDENT AGE LIMIT	To the end of the month in which the child attains age 26. For additional Dependent information such as Disabled Dependent eligibility, see the Eligibility and Enrollment section of this Benefit Booklet.

DEDUCTIBLE

	Network	**Non-Network**
Single	$2,500 Network and Non-Network combined	
Per Family	$5,000 Network and Non-Network combined	

Note: All medical and Prescription Drug Copayments/Coinsurance are subject to the Deductible and apply to the Out-of-Pocket Limit except for Non-Network Human Organ and Tissue Transplant Copayments/Coinsurance. The Deductible must be satisfied before any Covered Services are paid by the Plan except for services with no Copayment/Coinsurance.

OUT-OF-POCKET LIMIT

	Network	**Non-Network**
Single	$4,000 Network and Non-Network combined	
Per Family	$8,000 Network and Non-Network combined	

Note: **The Out-of-Pocket Limit includes all Deductibles and/or Copayments/Coinsurance you incur in a Benefit Period except for Non-Network Human Organ and Tissue Transplant Copayments/Coinsurance.** Once the Member and/or Family Out-of-Pocket Limit is satisfied, no additional Copayments/Coinsurance will be required for the Member and/or Family for the remainder of the Benefit Period except for Non-Network Human Organ and Tissue Transplant services.

Network and Non-Network Deductibles, Copayments, Coinsurance, and Out-of-Pocket Limits are not separate and do accumulate toward each other.

COVERED SERVICES	**COPAYMENTS/COINSURANCE/MAXIMUMS**	
	Network	**Non-Network**
Ambulance Services (Air and Water)	20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.

Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through Precertification. Please see “Health Care Management” for details.

Ambulance Services (Ground)	20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.

Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see "Health Care Management" for details.

Behavioral Health Services	20% Coinsurance	40% Coinsurance

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

Dental Services (only when related to accidental injury or for certain members requiring general anesthesia)	20% Coinsurance	40% Coinsurance

Diagnostic Services	When rendered as Physician Home Visits and Office Services or Outpatient Services the Copayment/Coinsurance is based on the setting where Covered Services are received except as listed below. Other Diagnostic Services and/or tests, including services received at an independent Network lab, may not require a Copayment/Coinsurance. Laboratory services provided by a facility participating in Administrator's Laboratory Network (as shown in the provider directory) may not require a Coinsurance/Copayment. If laboratory services are provided by an Outpatient Hospital laboratory which is not part of Administrator's Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit.

Note: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services are subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Emergency Room Services	20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.
Home Care Services	20% Coinsurance	40% Coinsurance
Maximum Visits per Benefit Period	Unlimited, combined Network and Non-Network	
NOTE: Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.		
Private Duty Nursing Maximum per Member per Benefit Period Lifetime Maximum	82 visits 164 visits	
Hospice Services	20% Coinsurance	20% Coinsurance
Inpatient and Outpatient Professional Services	20% Coinsurance	40% Coinsurance
Inpatient Facility Services	20% Coinsurance	40% Coinsurance
Maximum days per Benefit Period for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	Unlimited, combined Network and Non-Network	
Maximum days per Benefit Period for Skilled Nursing Facility	100 days, combined Network and Non-Network	
Mammograms (Outpatient diagnostic)	20% Coinsurance	40% Coinsurance
Maternity Services	20% Coinsurance	40% Coinsurance
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Network Pharmacy.)	20% Coinsurance	40% Coinsurance

NOTE: Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Maximum per Benefit Period for Wigs following cancer treatment	One wig per Benefit Period Network and Non-Network	

NOTE: If durable medical equipment or appliances are obtained through your Primary Care Physician or another Network Physician's office, Urgent Care Center Services, Outpatient Services, Home Health Care Services the Copayment/Coinsurance listed above will apply in addition to the Copayment/Coinsurance in the setting where Covered Services are received.

Outpatient Services		
Other Outpatient Services	20% Coinsurance	40% Coinsurance
Outpatient Surgery Hospital/Alternative Care Facility	20% Coinsurance	40% Coinsurance

Note: Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Physician Home Visits and Office Services		
Primary Care Physician (PCP)	20% Coinsurance	40% Coinsurance
Specialty Care Physician (SCP)	20% Coinsurance	40% Coinsurance
Allergy Injections	20% Coinsurance	40% Coinsurance

NOTES: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received in a Physician's office are subject to the Other Outpatient Services Copayment/Coinsurance.
The allergy injection Copayment/Coinsurance will be applied when the injection(s) is billed by itself. The office visit Copayment/Coinsurance will apply if an office visit is billed with an allergy injection.

Preventive Care Services	No Copayment / Coinsurance up to the Maximum Allowable Amount	40% Coinsurance (not subject to Deductible)
Surgical Services	20% Coinsurance	40% Coinsurance
Temporomandibular Joint (TMJ) Services (surgical and non-surgical)	20% Coinsurance	40% Coinsurance
Therapy Services	20% Coinsurance	40% Coinsurance

NOTE: If different types of Therapy Services are performed during one Physician Home Visit, 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 Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.

Maximum Visits per Benefit Period for:		
Physical Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.	
Occupational Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.	
Speech Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.	
Manipulation Therapy	12 visits combined Network & Non-Network	
Urgent Care Center Services	20% Coinsurance	20% Coinsurance. You are responsible for any amounts charged that exceed the Maximum Allowable Amount.

Human Organ and Tissue Transplant Services

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above services are paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to applicable Member cost shares.

Transplant Benefit Period	**Network Transplant Provider** Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34 - 50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility.	**Non-Network Transplant Provider** The later of 30 days or date of discharge following a Covered Transplant Procedure at a Non Network Transplant Provider Facility.
Deductible	**Network Transplant Provider** Applicable	**Non-Network Transplant Provider** Applicable During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.
Covered Transplant Procedure during the Transplant Benefit Period	**Network Transplant Provider** 20% Coinsurance Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.	**Non-Network Transplant Provider** During the Transplant Benefit Period, You will pay 40% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also a Network Provider for this Certificate (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 the Plan, you **will** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	**Network Transplant Provider Professional and Ancillary (non-Hospital) Providers** 20% Coinsurance	**Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers** You are responsible for 40% of Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	Covered, as approved through the plan's prior approval and precertification process, up to a $10,000 benefit limit	For Transplants received at a Non-Network Transplant Provider Facility, covered as approved through the plan's prior approval and precertification process, up to a maximum of $10,000 in charges. You will pay 50% of the approved amount. These charges will NOT apply to your Out-of-Pocket Limit.
Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure	Covered, as approved through the plan's prior approval and precertification process, up to a $30,000 benefit limit	Covered, as approved through the plan's prior approval and precertification process, up to a $30,000 benefit limit. You will be responsible for 50% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.

Live Donor Health Services	Covered as approved through the plan's prior approval and precertification process	You will pay 40% of the Plan's Maximum Allowable Amount for Medically Necessary live organ donor expenses. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement. These charges will NOT apply to your Out-of-Pocket Limit.

5 COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **For most services, care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider to be a Covered Service, except for Emergency Care and Urgent Care. Services which are not received from a PCP, SCP or another Network Provider or approved as an Authorized Service will be considered a Non-Network service, except as specified above.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care and Urgent Care.

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 Coinsurance, Copayment or Deductible. The Plan 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 Plan, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization/Precertification has been obtained. The Administrator bases its' decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on the Administrator's clinical coverage guidelines and medical policy. The Administrator 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. The Plan's payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible or Benefit Period Limit/Maximum in this Benefit Booklet.**

Ambulance Services

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

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when We require you to move from a Non-Network Hospital to a Network Hospital
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when We require you to move from a Non-Network Hospital to a Network Hospital
  - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by Us. When using an air ambulance, We reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider We select, the Non-Network Provider may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

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

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

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

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

a) A Doctor's office or clinic;

b) A morgue or funeral home.

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Autism Spectrum Disorder Services

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Benefit Booklet in conflict with the coverage described in this provision will not apply. Coverage for autism spectrum disorders will not be subject to dollar limits, Deductibles, Copayment or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to physical illness under this Plan.

Behavioral Health Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for Inpatient Services, Outpatient Services, and Physician Home Visits & Office Services for the treatment of Behavioral Health conditions is provided in compliance with federal law.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification .
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
  - Observation and assessment by a psychiatrist weekly or more often,
  - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,

- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when the Plan has to cover them by law.

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a. The National Institutes of Health.
   b. The Centers for Disease Control and Prevention.
   c. The Agency for Health Care Research and Quality.
   d. The Centers for Medicare & Medicaid Services.
   e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services

that are not part of approved clinical trials will be reviewed according to the Administrator's Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or

ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

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

Related to Accidental Injury

Outpatient Services, Physician Home Visits and 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 unless the chewing or biting results from an act or domestic violence or directly from a medical condition. "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.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member who is physically or mentally disabled, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Diabetic Equipment, Education and Supplies

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

Diabetes Self Management Training 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.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See "Medical Supplies, Durable Medical Equipment and Appliances", "Preventive Care Services", and "Physician Home Visits and Office Services". Screenings for gestational diabetes are covered under "Preventive Care."

Diagnostic Services

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

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 Physician Home Visits and 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 Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.

- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- 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).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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.

For Diagnostic services other than those approved to be received in a Physician's office, you may be required to use the Administrator's independent laboratory Network Provider called the Reference Laboratory Network (RLN).

When Diagnostic services are performed within 3 days (72 hours) as part of pre-admission testing required for an Inpatient admission or an Outpatient surgery, no Copayment is required. Any Coinsurance will still apply.

Emergency Care and Urgent Care Services

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

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Medically Necessary services which the Administrator determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider.

Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method the Administrator generally uses to determine payments for Non-Network services but substituting the Network cost-sharing provisions for the Non-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

In addition, 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.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs, Physician services and supplies.

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 of your admission within 48 hours or as soon as possible within a reasonable period of time. When the Administrator 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, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with the Administrator or is a BlueCard Provider, you will be financially responsible for any care the Administrator, on behalf of the Employer, determines is not Medically Necessary.

Care and treatment provided once you are Stabilized is no longer considered 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 a Non-Network service unless the Administrator authorizes the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Covered Services rendered by a Non-Network Urgent Care Center will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. If you experience an accidental

injury or a medical problem, the Plan 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.

Home Care Services

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

Covered Services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.
- Nutritional Guidance.
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by the Administrator, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). 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.

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).

- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy 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

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

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

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

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

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Benefit Booklet.

Inpatient Services

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

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- 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 use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Administrator. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) 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.
- 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; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone 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.

Maternity Services

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

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, and ordinary routine nursery care for a healthy newborn.

If the Member is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Network Provider to have Covered Services paid at the Network level. If the Member is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period. The Member must complete a Continuation of Care Request Form and submit to the Administrator.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Coinsurance/Copayment.

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 Perinatal 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 post-discharge 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 performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

  1. parent education;
  2. assistance and training in breast or bottle feeding; and
  3. 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.

In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

- Phenylketonuria.
- Hypothyroidism.
- Galactosemia.
- Homocystinuria.
- Maple syrup urine disease.
- Hemoglobinopathies, including sickle cell anemia.
- Congenital adrenal hyperplasia.
- Biotinidase deficiency.
- Cystic fibrosis.
- Hearing impairment.
- Other genetic conditions that are detectable at birth via newborn screening methods, including, but not limited to, the following:

  1. Tandem mass spectrometry (MS/MS).
  2. High volume radioimmunoassay.
  3. Hemoglobin electrophoresis.
  4. Isoelectric focusing.
  5. Bacterial inhibition assays.
  6. Immunoreactive trypsin (IRT).

7. DNA testing.

Abortion Services - Benefits include services for an abortion performed if:

- A woman becomes pregnant through an act of rape or incest.
- An abortion is necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

Medical Supplies, Durable Medical Equipment, and Appliances

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

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.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by the Administrator, on behalf of the Employer. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).
- In addition, replacement of purchased equipment, supplies or appliance may be covered if:
  1. The equipment, supply or appliance is worn out or no longer functions.
  2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
  3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
  4. The equipment, supply or appliance is damaged and cannot be repaired.

The Administrator may establish reasonable quantity limits for certain supplies, equipment or appliance described below.

Covered Services may include, but are not limited to:

- **Medical and surgical supplies** – Certain supplies and equipment for the management of disease that the Administrator approves are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Plan's Prescription Drug benefit: Syringes, needles, oxygen, surgical dressings, splints and other similar

items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self administered and are provided in a Physician's office, including but not limited to, Depo-Provera. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1. Allergy serum extracts
2. Chem strips, Glucometer, Lancets
3. Clinitest
4. Elastic stockings or supports. These items must be purchased by prescription or through a Hospital. They must be Medically Necessary for the treatment of an injury or condition requiring stockings. We may establish reasonable limits on the number of pairs allowed per Member per Benefit Period.
5. Needles/syringes
6. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services
7. Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease is covered. Medical foods 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.

Non Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators
2. Arch supports
3. Doughnut cushions
4. Hot packs, ice bags
5. Vitamins
6. Medi-jectors

If you have any questions regarding whether a specific medical or surgical supply is covered, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **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; 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, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

  Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube
7. Cardiac, neonatal and sleep apnea monitors
8. Augmentive communication devices are covered when the Administrator approves based on the Member's condition.

Non-covered items may include but are not limited to:

1. Air conditioners
2. Ice bags/coldpack pump
3. Raised toilet seats
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Prosthetics** – 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.

  Prosthetic devices should be purchased not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may 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. Maximums for Prosthetic devices, if any, do not apply.

4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
5. 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). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs following cancer treatment, limited to the maximum shown in the Schedule of Benefits.

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. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury

If you have any questions regarding whether a specific prosthetic is covered, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **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. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices may 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.

Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
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.

If you have any questions regarding whether a specific orthotic is covered, call the customer service number on the back of your Identification Card or visit the Administrator's website at www.anthem.com.

- **Prosthetic limbs & Orthotic custom fabricated brace or support** - Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1. determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
  2. not solely for comfort or convenience.

  Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

  Prosthetic limbs and Orthotic custom fabricated braces or supports designed as components for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Outpatient Services

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

Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan.

These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by the Administrator, on behalf of the Employer. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

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

Physician Home Visits and Office Services

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

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Care", "Maternity Care", and "Home Care Services" for services covered by the Plan. For Emergency 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 also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

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

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

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

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Preventive Care Services

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

Preventive Care services include, Outpatient services and Office Services. Screenings and other services are 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.

Preventive Care Services in this section shall meet requirements as determined by federal law. Many preventive care services are covered by this Plan with no Deductible, Copayments or Coinsurance from the Member when provided by a Network Provider. That means the Plan pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force.

   Examples of these services are screenings for:

   a. Breast cancer;
   b. Cervical cancer;
   c. Colorectal cancer;
   d. High Blood Pressure;
   e. Type 2 Diabetes Mellitus;
   f. Cholesterol;
   g. Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

   a. Generic women’s contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.}
   b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.
   c. Gestational diabetes screening.

You may call Customer Service using the number on your ID card for additional information about these services. (or view the federal government’s web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.)

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

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- 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.

  Other Covered Services are:

- Routine hearing screenings
- Routine vision screenings

Surgical Services

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

Coverage for Surgical Services when provided as part of Physician Home Visits and 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;
- Other procedures as approved by the Administrator, on behalf of 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, on behalf of the Employer 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.

Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered. Covered Services include the following:

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

Surgical Services for Morbid Obesity, described in more detail below, shall be covered the same as any other Medically Necessary Surgical Service subject to any maximums in the Schedule of Benefits.

Reconstructive Services

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance . Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: Coverage for reconstructive services does not apply to orthognathic surgery. See the “Surgical Services ” section above for that benefit.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, 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, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Morbid Obesity Treatment Services

Covered Services include surgical treatment of morbid obesity:

- that has persisted for at least five (5) years; and
- for which nonsurgical treatment supervised by a Physician has been unsuccessful for at least six (6) consecutive months.

The Plan will not cover services for the surgical treatment of morbid obesity for a Member younger than 21 years of age unless two (2) Physicians licensed under Indiana Code 25-22.5 (one who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in Indiana) determine that the surgery is necessary to:

- save the life of the Member; or
- restore the Member's ability to maintain a major life activity (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency);

and each Physician documents in the Member's medical record the reason for the Physician's determination.

"Morbid obesity" means:

- a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- a body mass index of at least forty (40) kilograms per meter squared without comorbidity.

For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.

Sterilization

Sterilization is a Covered Service. Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section for further details.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

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

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

Therapy Services

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

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy 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. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **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, or vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for

newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations 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 Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

- **Chemotherapy** for the treatment of a 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. As a condition of coverage the Plan will not require you to receive dialysis treatment at a Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

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 Inpatient 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.

Non-Covered Services for physical medicine and rehabilitation include, but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Human Organ and Tissue Transplant Services

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

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure

Any Medically Necessary human organ and tissue transplants or transfusions as determined by the Administrator, on behalf of the Employer including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34 -50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility or the later of 30 days or date of discharge following a Covered Transplant Procedure at a Non-Network Transplant Provider Facility.

Prior Approval and Precertification

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

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

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Administrator, on behalf of the Employer when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Administrator when claims are filed. Contact the Administrator for detailed information.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

6 NON-COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded and are not Covered Services. Unless otherwise stated in this Plan's Benefits' Article, no benefits are provided for care and supplies related to:

- Human organ or tissue transplants other than as specifically stated as covered in the Benefits' Article.

- Artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
- Artificial insemination.
- In vitro fertilization.
- Gamete intra fallopian transfer (GIFT).
- Immunizations except as specifically stated.
- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- Reversal of sterilization.
- Services or supplies prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- 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.
- Hearing aids or examinations for prescribing or fitting them.
- Services, supplies, or charges which the Plan determines are not Medically Necessary or do not meet the Plan's medical policy, clinical coverage guidelines, or benefit policy guidelines.
- Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional.This includes services at residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. However, mental health and substance abuse residential treatment is a covered benefit.
- Dental treatment, regardless of origin or cause, except as specified elsewhere in this Plan's Benefits' Article. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service as stated in this Plan's Benefits' Article) or gums, including but not limited to: extraction, restoration and replacement of teeth;
    - Medical or surgical treatments of dental conditions; and
    - Services to improve dental clinical outcomes.
- Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- Dental implants.
- Dental braces.

- Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:

  1. transplant preparation;
  2. initiation of immunosuppresives; or
  3. direct treatment of acute traumatic injury, cancer or cleft palate.

- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
- Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in this Plan's Benefits' Article.
- Routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:

  1. cleaning and soaking the feet;
  2. applying skin creams in order to maintain skin tone; or
  3. other services that are performed when there is not a localized illness, injury or symptom involving the foot.

- Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 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, 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.
- Examinations relating to research screenings.
- Developmental delays except for Pervasive Developmental Disorders (including Asperger's syndrome and autism) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, learning disabilities, hyperkinetic syndromes, or mental retardation.
- Illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
- Services and supplies for which you have no legal obligation to pay in the absence of this or like coverage.
- Services and supplies incurred prior to your Effective Date.
- Services and supplies incurred after the termination date of this coverage except as specified elsewhere.
- Services or supplies provided by a sanitarium, or rest cures.

- Services or supplies furnished by any person or institution acting beyond the scope of her/his/its license.
- Plan benefits to the extent that the services are a Medicare Part A or Part B liability.
- Services and supplies 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.
- Services and supplies to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- Mileage, lodging and meals costs, and other Covered Person's travel related expenses, except as authorized by the Plan or specifically stated as a Covered Service. Services or supplies if the Plan does not state that benefits are provided for them.
- Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by the Plan.
- Missed or canceled appointments.
- Completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Recreation or diversional therapy.
- The cost of materials used in any Occupational Therapy.
- Personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.
- Hospitalization for environmental change or Provider charges connected with prescribing an environmental change.
- Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in this Plan's Benefits' Article. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity as required by law are covered. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
- Stand-by charges of a Physician.
- Sex transformation and/or the reversal thereof, 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.
- Drugs in quantities which exceed the limits established by the Plan.

- Prescription Drug, except as provided through the Pharmacy Benefits Manager.
- The Prescription Drug Copayment portion of the Pharmacy Benefits Manager.
- Any medications dispensed in a physician's office.
- 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.
- Diagnostic testing or treatment related to infertility.
- Marital counseling.
- Services and supplies received from an individual or entity that is not a Provider, as defined in this Plan's Benefits' Article, or recognized by the Plan.
- A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- Services which are performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
- Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- Expenses incurred at a health spa or similar facility.
- Self-help training and other forms of non-medical self care, except as otherwise provided herein.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, or for licensing.

EXPERIMENTAL/INVESTIGATIVE SERVICES

- 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 Plan determines to be Experimental/Investigative is not covered under the Plan.

  The Plan will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if it 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 Plan. In determining whether a Service is Experimental/Investigative, the Plan 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 Plan to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

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

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

- 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.
- Court ordered testing or care unless Medically Necessary.
- Charges in excess of the Maximum Allowable Amount.
- 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. Complications directly related to cosmetic services treatment or surgery are not covered.
- Vision orthoptic training.
- Care received in an emergency room which is not Emergency Care, except as specified as covered.
- Chiropractic services rendered in the home as part of Home Care Services.
- Alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.
- Hiring, or the services of, a surrogate mother.
- Surgical treatment of gynecomastia.
- Treatment of hyperhydrosis (excessive sweating).
- Any service for which a Covered Person is responsible under the terms of this Plan to pay a Copayment or Coinsurance and the Copayment or Coinsurance is waived by a non-Network Provider.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Elective abortions.

7 ELIGIBILITY AND ENROLLMENT

You have coverage provided under the Plan because of your employment with/membership with/retirement from the Employer. You must satisfy certain requirements to participate in the Employer's benefit plan. These requirements may include probationary or waiting periods and Actively

At Work standards as determined by the Employer or state and/or federal law and approved by the Administrator, on behalf of the Employer.

Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.

Eligibility

- All active, full-time employees and their eligible "dependents" are eligible to participate. For the purpose of benefits eligibility, full-time employees are defined as active employees whose regular work schedule is at least 37 1/2 hours per week. Part-time, intermittent and hourly (temporary) employees who worked an average of thirty (30) or more hours per week over a 12-month review period would also be eligible for benefits. Part-time, intermittent and hourly (temporary) employees working less than thirty (30) or more hours per week over a 12-month review period are not eligible for insurance or related benefits.

- All appointed or elected officials and their eligible “dependents”.

- Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.

- "Dependent” means:

  a) Spouse of an employee;

  b) Any children, step-children, foster children, legally adopted children of the employee or spouse, or children for whom the employee or spouse has been appointed legal guardian or awarded legal custody by a court, or children under the age of 26, or who the Group has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law. Such child shall remain a “dependent” until the end of the month the child turns age twenty-six (26). In the event a child who is a “dependent” as defined herein, is both:

  1. incapable of self-sustaining employment by reason of mental or physical disability, and
  2. is chiefly dependent upon the employee for support and maintenance;

  prior to age 19, such child’s coverage shall continue if satisfactory evidence of such disability and dependency is received within 120 days after the maximum age is attained. Coverage for the “dependent” will continue until the employee discontinues his coverage or the disability no longer exists. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires annual documentation from a physician after the child’s attainment of the limiting age.

- A group health coverage program that is equal to that offered active employees shall be provided by the State for each “Retired Legislator” who meets the following:

  a) Is no longer a member of the General Assembly;

  b) Who served as a legislator for at least 10 years.

A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's Spouse covered under the health insurance program. In addition, the surviving Spouse of a legislator who has died may elect to participate in the group health insurance program if all of the following apply:

1. The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the date of the legislator's death;
2. The surviving Spouse files a written request for insurance coverage with the employer;
3. The surviving Spouse pays an amount equal to the employer's and employee's premium for the group health coverage for an active employee.

- The eligibility of the retired legislator's Spouse, or a surviving Spouse of a legislator for group health coverage is not affected by the death of the retired legislator and is not affected by the retired legislator's eligibility for Medicare. The Spouse's eligibility ends on the earliest of the following:

1. When the employer terminates the health coverage program;
2. The date of the Spouse's remarriage;

IC 5-10-8-8.2 Former Legislators

Sec. 8.2 (a) As used in this section, "former legislator" means a former legislator or spouse of a former legislator; or

1. is:

A) a dependent child, stepchild, foster child, or adopted child of a former legislator or spouse of a former legislator; or

B) a child who resides in the home of a former legislator who has been appointed legal guardian of the child; and

2. is:

A) less than the end of the month the child turns twenty-six (26) years of age;

B) at least until the end of the month the child turns twenty-six (26) years of age, incapable of self-sustaining
employment by reason of mental or physical disability, and is chiefly dependent on a former legislator or spouse of a former legislator for support and maintenance.

- "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

a) Must retire before January 1, 2007

b) Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;

c) Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;

d) Must have fifteen (15) years of participation in a retirement fund.

- "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

i. Must retire after December 31, 2006.

ii. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;

iii. Must have completed fifteen (15) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement.

- "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

i. Must have been employed as a teacher in a State institution under IC 11-10-5, IC 12-24-3, IC 16-33-3, or IC 16-33-4;

ii. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;

iii. Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement;

- A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:

a) Retirement date is after June 30, 1990;

b) Will have reached the age of sixty-two (62) on or before retirement date;

c) Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;

d) Who has at least eight (8) years of service credit as a participant in the Judge's retirement fund, with at least eight (8) years of service credit completed immediately preceding the Judge's retirement.

- A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:

a) Who is a retired participant under the Prosecuting Attorney's Retirement fund;

b) Whose retirement date is after January 1, 1990;

c) Who is at least sixty-two (62) years of age;

d) Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and

e) Who has at least ten (10) years of service credit as a participant in the Prosecuting Attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.

- Retirees eligible under subsections 6 - 10 must file a written request for the coverage within ninety (90) days after retirement. The Spouse's subsequent eligibility to continue insurance under the surviving Spouse's eligibility end on the earliest of the following:

a) Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the Spouse would be eligible to remain covered until the end of the maximum period under COBRA;

b) When the Spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

c) The end of the month following remarriage; or

d) As otherwise provided in I.C. 5-10-8-8(g).

- Employee on a leave of absence for ninety (90) days or less and out of pay status
- An employee on family leave
- Retirees eligible under IC 5-10-12.
- A former legislator, dependent, or Spouse as defined and pursuant to the conditions set forth in IC 5-10-8-8.2.
- As otherwise provided by Act of the Indiana General Assembly.

Effective Date Of Your Coverage

"For specific information concerning your Effective Date of coverage under this Plan, you should see your Human Resources or benefits department."

Coverage for a newborn child is effective from the moment of birth. Covered Services include the treatment of any injury or illness such as congenital deformity, hereditary complication, premature birth, and routine nursery care. Newborn must be formally added to Employee's policy through "family status" change process. See NEWBORN INFANT COVERAGE.

Newborn Infant Coverage

The benefits payable for covered Dependent children shall be paid for a sick or injured newborn infant of a Covered Person for the first 30 days of his or her life. The coverage for newly adopted children will be the same as for other covered Dependents. The coverage for the newborn infant or newly adopted child consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage for the newborn infant or newly adopted child shall include, but not be limited to, benefits for Inpatient or Outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

The coverage required for a newly adopted child:

- Is effective upon the earlier of:
  - **a)** The date of placement for the purpose of adoption; or
  - **b)** The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption;
- Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or
- Continues unless required action as described below is not taken.

To be covered beyond the first 30 days, the newborn or newly adopted child must be added to the Covered Person's Plan Enrollment within the first 30 days after birth or adoption.

If the Enrollee must change to coverage with a higher fee to add the child, the Enrollee will be liable for the higher fee for the entire period of the child's coverage, including the first 30 days.

Federal Laws Related To Your Coverage

In the past few years, Congress has passed several laws that have affected our group health plans. These laws are designed to reduce Medicare expenditures by requiring that active employees and/or their Dependents who are either age 65 or over, or disabled to elect either:

a) our group health Plan, or

b) Medicare as their primary coverage.

The preference is option (a) since option (b) would require the discontinuance of the group medical Plan. In addition, Medicare no longer requires enrollment in the Part B Supplemental Medical Insurance Benefit for which there is a charge so long as you remain covered under our group medical Plan.

8 CHANGES IN COVERAGE: TERMINATION, CONTINUATION & CONVERSION

Individual Termination

Your coverage will terminate on the earliest of the following dates:

- On the date the group Plan is terminated.
- On the last day of the period for which premiums have been paid, if the State of Indiana fails to pay the required premiums for you, except when resulting from clerical mistake or inadvertent error.
- On the last day of the period for which premiums have been paid in which you leave or are dismissed from employment.
- On the date your Dependent(s) cease(s) to be an eligible Dependent.
- Upon the date of your death, coverage for your Dependents shall terminate at the end of the period for which premiums have been paid.

Continuation

Federal Continuation of Coverage (COBRA)

The following applies if you are covered under an Employer which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Employer's health plan. It can also become available to other Members of your family, who are covered under the Employer's health plan, when they would otherwise lose their health coverage. For additional information about your rights and obligations under federal law under the coverage provided by the Employer's health plan, you should contact the Employer.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Employer's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Employer's health plan is lost because of the qualifying event. Under the Employer's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Employer for Fees payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Employer's health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Employer's health plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Employer's health plan as a "Dependent child."

If Your Employer Offers Retirement Coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Employer's health plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under Employer's health plan.

When is COBRA Coverage Available

The Employer will offer COBRA continuation coverage to qualified beneficiaries only after the Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), then the Employer will notify the COBRA Administrator (e.g., Human Resources, external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided

Once the Employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

How Long Will Continuation Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued only for up to a total of 18 months. In the case of losses of coverage due to the Subscriber's death, divorce or legal separation, the Subscriber's becoming entitled to Medicare benefits or a Dependent child ceasing to be a Dependent under the terms of the Employer's health plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement.

How Can You Extend The Length of COBRA Continuation Coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Employer of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

- Disability

  An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. You must provide the SSA determination of your disability to the Employer within 60 days of receipt. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at

least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Employer of that fact within 30 days after SSA's determination.

- Second Qualifying Event

  An 18-month extension of coverage will be available to spouses and Dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Subscriber, divorce or separation from the covered Subscriber, the covered Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Employer's health plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Employer within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Trade Act of 1974

Special COBRA rights apply to Subscribers who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their Employer health plan coverage ended.

If you, the Subscriber, qualify for assistance under the Trade Act of 1974, you should contact the Employer for additional information. You must contact the Employer promptly after qualifying for assistance under the Trade Act of 1974 or you will lose these special COBRA rights.

Premiums and the End of COBRA Coverage

Premium will be no more than 102% of the Employer rate (unless your coverage continues beyond 18 months because of a disability. In that case, premium in the 19th through 29th months may be 150% of the Employer rate).

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another Employer health plan,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Employer would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Other coverage options besides COBRA Continuation Coverage

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

If You Have Questions

Questions concerning your Employer's health plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Indiana Public Employee Continuation of Coverage

If you are covered through an Employer that is a local unit public employer, as defined by Indiana law, you may be eligible for continuation of coverage under this Plan beyond the date your coverage would otherwise end. Please see your Employer's Human Resources or benefits department for further information concerning your eligibility for continuation of coverage.

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under the Plan by notifying your employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If Your military service is for a period of time less than 31 days, You may not be required to pay more than the active Member contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under the Plan shall be the lesser of:

1. The 24-month period beginning on the first date of your absence from work; or
2. The day after the date on which You fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under

the Plan. No exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting. To obtain coverage for a Subscriber upon return from leave under the Act, the Employer must provide the Administrator with evidence satisfactory to the Employer of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

9 HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Service from Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care, Urgent Care, or as an Authorized Service**. Contact a PCP, SCP, other Network Provider, or the Administrator to be sure that Prior Authorization and/or precertification has been obtained.

If a Non-Network Provider meets the Administrator's enrollment criteria and is willing to meet the terms and conditions for participation, that Provider has the right to become a Network Provider for the product associated with the Plan.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider benefits will be paid at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another Network Provider. All medical care must be under the direction of Physicians. The Administrator, on behalf of the Employer, has final authority to determine the Medical Necessity of the service.

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. You may appeal this decision. See the Your Right To Appeal section of this Benefit Booklet.

- **Network Providers** - include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional Providers, Hospitals, and other facility Providers who contract with the Administrator to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatrician or other Network Providers

as allowed by the Plan. The Primary Care Physician is the Physician who may provide, coordinate, and arrange your health care services. SCP's are Network Physician who provide specialty medical services not normally provided by a PCP. Referrals are never needed to visit a Network Specialist including behavioral health Providers.

To see a doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.
- When you go to the office, be sure to bring your Member Identification Card with you.

For services rendered by Network Providers:

1. 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 Coinsurance, Copayments and/or Deductibles. You may be billed by your Network Provider(s) for any non-Covered Services you receive or when you have not acted in accordance with the Plan.
2. Health Care Management is the responsibility of the Network Provider.

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 may approve a Non-Network Provider for that service as an Authorized Service.

After Hours Care

If you need care after normal business hours, your doctor may have several options for you. You should call your doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

How to Find a Provider in the Network

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

- See the directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this plan's network.
- Call Customer Service to ask for a list of doctors and Providers that participate in this plan's network, based on specialty and geographic area.
- Check with your doctor or Provider.

Please note that not all Network Providers offer all services. For example, some Hospital-based labs are not part of the Administrator's Reference Lab Network. In those cases you will have to go to a lab in the Administrator's Reference Lab Network to get Network benefits. Please call Customer Service before you get services for more information.

If you need help choosing a doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with the Administrator to help with your needs.

Non-Network Services

Services which are not obtained from a PCP, SCP, or another Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exception is 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:

- The difference between the actual charge and the Maximum Allowable Amount plus any Deductible and/or Coinsurance/Copayments;
- Services that are not Medically Necessary;
- Non-Covered Services;
- Filing claims; and
- Higher cost sharing amounts.

Relationship of Parties (Plan - Network Providers)

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

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network 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, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

Not Liable for Provider Acts or Omissions

The Plan is 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 Plan based on the actions of a Provider of health care, services or supplies.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under the Plan has the right to services or benefits under the Plan. If anyone receives services or benefits to which they are not entitled to under the terms of this Benefit Booklet, he/she is responsible for the actual cost of the services or benefits.

10 CLAIMS PAYMENT

When you receive care through a Network Provider, you are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim.

A claim must be filed for you to receive Non-Network Services benefits, but many Non-Network Hospitals, Physicians and other Providers will still submit your claim for you. If you submit the claim, use a claim form.

How Benefits Are Paid

Maximum Allowed Amount

General

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

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

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

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

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

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

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

Provider Network Status

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

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

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

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

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

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

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

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

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

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

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

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

For Prescription Drugs: The Maximum Allowed Amount is the amount determined by the Administrator using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM).

Member Cost Share

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

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Non-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on your benefits when using Non-Network Providers. Please see the Schedule of Benefits in this Certificate for your cost share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or cost share amounts may vary by the type of Provider You use.

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

In some instances You may only be asked to pay the lower Network cost sharing amount when You use a Non-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

The following are examples for illustrative purposes only; the amounts shown may be different than this Benefit Booklet's cost share amounts; see Your Schedule of Benefits for

Your applicable amounts.

Example: Your plan has a Coinsurance cost share of 20% for Network services, and 30% for Non-Network services after the Network or Non-Network Deductible has been met.

You undergo a surgical procedure in a Network Hospital. The Hospital has contracted with a Non-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- *The Non-Network anesthesiologist's charge for the service is $1200. The Maximum Allowed Amount for the anesthesiology service is $950; Your Coinsurance responsibility is 20% of $950, or $190 and the remaining allowance from the Plan is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the Deductible has been met, your total Out of Pocket responsibility would be $190 (20% Coinsurance responsibility) plus an additional $250, for a total of $440.*
- *You choose a Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; Your Coinsurance responsibility when a Network surgeon is used is 20% of $1500, or $300. The Plan allows 80% of $1500, or $1200. The Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be $300.*
- *You choose a **NON-NETWORK** surgeon. The Non-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; Your Coinsurance responsibility for the NON-NETWORK surgeon is 30% of $1500, or $450 after the NON-NETWORK Deductible has been met. The Plan allows the remaining 70% of $1500, or $1050. **In addition**, the Non-Network surgeon could bill You the difference between $2500 and $1500, so your total Out of Pocket charge would be $450 plus an additional $1000, for a total of **$1450**.*

Authorized Services

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

The following are examples for illustrative purposes only; the amounts shown may be different than this Benefit Booklet's cost share amounts; see Your Schedule of Benefits for Your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no Network Provider for that specialty in your state of residence. You contact the Administrator in advance of receiving any Covered Services, and the Plan authorizes You to go to an available Non-Network Provider for that Covered Service and the Plan agrees that the Network cost share will apply.

Your plan has a $45 Copayment for Non-Network Providers and a $25 Copayment for Network Providers for the Covered Service. The Non-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because the Plan have authorized the Network cost share amount to apply in this situation, You will be responsible for the Network Copayment of $25 and the Plan will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Network Provider's charge for this service is $500, You may receive a bill from the Non-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your Network Copayment of $25, your total out of pocket expense would be $325.

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.

Claims Review

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

Payment of Benefits

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

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

Notice of Claim

The Plan is not liable, unless the Administrator receives written notice that Covered Services have been given to you. The notice must be given to the Administrator, on behalf of the Employer, 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, on behalf of the Employer, generally will make its request for additional information within 30 days of the Administrator's initial receipt of the claim and will complete the Administrator's 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. **If the Administrator is unable to complete processing of a claim because you or your Provider fail to provide the Administrator with the additional information within 60 days of its request, the claim will be denied and you will be financially responsible for the claim.**

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.

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 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 initial receipt of the claim and will complete the Administrator's processing of the claim within 15 days after the Administrator's receipt of all requested information.

At the Plan'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.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to the Administrator, or contact customer service and ask for claim forms to be sent to you. If you do not receive the claim forms, written notice of services rendered may be submitted to the Administrator 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 Provider's signature.

Member's Cooperation

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

Explanation of Benefits (EOB)

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 from the Plan 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 for ERISA plans, information regarding the right to bring action after the Appeals Process.

Inter-Plan Programs

Out-of-Area Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of Anthem's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

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

BlueCard® Program

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

Whenever you access covered healthcare services outside Anthem's Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

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

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

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

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Administrator would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

Member Liability Calculation

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

Exceptions

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

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

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Customer Service at the number on your Identification Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and the Administrator suggest:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
- Always carry your up to date Anthem Identification Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call the Administrator to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to the Administrator.

Claim Forms

You can get international claim forms from the Administrator, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

11 HEALTH CARE MANAGEMENT

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

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

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

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Physician must notify the Administrator within 48 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

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

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

Most Network Providers know which services require Precertification and will obtain any required Precertification or request a Predetermination if they feel it is necessary. Your Primary Care Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care

Management are met. The ordering Provider, facility or attending Physician will contact the Administrator to request a Precertification or Predetermination review ("requesting Provider"). The Administrator will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services provided by a Network Provider	**Services provided by a BlueCard/Non-Network/Non-Participating Provider**
Provider	• Member is responsible for Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions you, your authorized representative, or Physician must notify the Administrator within 24 hours of the admission or as soon as possible within a reasonable period of time.

The Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines, and other applicable policies and procedures to assist in making Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. The Administrator reserves the right to review and update these clinical coverage guidelines periodically. Your Benefit Booklet and the Administrative Services Agreement take precedence over these guidelines.

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

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

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

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

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

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

Request Categories:

Urgent – a request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the member to severe pain that cannot be adequately managed without such care or treatment.

Prospective – a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.

Concurrent / Continued Stay Review - a request for Precertification or Predetermination that is conducted during the course of Outpatient treatment or during an Inpatient admission.

Retrospective - a request for Precertification that is conducted after the service, treatment or admission has occurred. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, the Administrator will abide by state regulations. You may call the telephone number on the back of your membership card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non-Urgent	2 business days from the receipt of the request
Concurrent / Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent / Continued Stay Review Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours or 2 business days from the receipt of request whichever is less
Concurrent / Continued Stay Review Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	

Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent / Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent / Continued Stay Review Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent / Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request

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

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

Verbal: oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.

Written: mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the member or authorized member representative.

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

1. you must be eligible for benefits;
2. premium must be paid for the time period that services are rendered;
3. the service or surgery must be a Covered Service under the Plan;
4. the service cannot be subject to an exclusion under the Plan; and
5. you must not have exceeded any applicable limits under the Plan.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

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

The Administrator's Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of,

your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

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

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

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

Voluntary Clinical Quality Programs

The Administrator may offer additional opportunities to assist You in obtaining certain covered preventive or other care (e .g., well child check-ups or certain laboratory screening tests) within a specific timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under this Plan. These programs are not guaranteed and could be discontinued at any time. The Administrator will give you the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, You may receive incentives such as gift cards. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If You receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to You. For additional guidance, please consult Your tax advisor.)

Value-Added Programs

The Administrator may offer health or fitness related programs to the Plan's Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under the Plan and could be discontinued at any time. The Administrator does not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

12 YOUR RIGHT TO APPEAL

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

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

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

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

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

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

Notice of Adverse Benefit Determination

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

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and

- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

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

Appeals

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

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

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

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

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

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568; Atlanta, GA 30348-5568.

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

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

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

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

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

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

External Review

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

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

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

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

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

Anthem Blue Cross and Blue Shield, ATTN: Appeals, , P.O. Box 105568; Atlanta, GA 30348-5568.

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

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

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

13 GENERAL PROVISIONS

Entire Contract

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Employer and any and all statements made to the Employer by the Plan 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 a person authorized to sign on behalf of the Employer.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that they, in consultation with their Providers, are responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment recommended by your 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. In this event, the Provider shall have no further responsibility to provide care to you, and the Plan shall have no obligation to have Network Providers available who will render the care.

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 Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, the Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of the Plan, disability affecting a significant number of a Network Provider's staff or similar causes, or health care services provided under the Plan are delayed or considered impractical. Under such circumstances, the Plan and Network Providers will provide the health care services covered by the Plan as far as is practical under the circumstances, and according to their best judgment. However, the Plan and Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of the Plan.

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

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

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

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

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

COB Definitions

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate

contracts are considered parts of the same Plan and there is no COB among those separate contracts.

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

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

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

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

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

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

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

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

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

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

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

5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     - The Plan covering the Custodial parent;
     - The Plan covering the spouse of the Custodial parent;
     - The Plan covering the non-custodial parent; and then
     - The Plan covering the spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

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

this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by state or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

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

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

Effect on this Plan's Benefits

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

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

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Administrator, on behalf of the Employer, may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The 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 the Administrator need to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That

amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

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

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

Medicare

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) 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. 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 Parts B, the Plan will calculate benefits as if they had enrolled.

Physical Examination

When a claim is pending, the Plan reserves the right to request a Member to be examined by an applicable Provider. This will be requested as often as reasonably required.

Workers' Compensation

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

Other Government Programs

The benefits under the Plan shall not duplicate any benefits that Members are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require the Plan to be the primary payor. If the Plan has duplicated such benefits, all money paid by such programs to Members for services they have or are receiving, shall be paid by or on behalf of the Member to the Plan.

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your injuries. The following apply:

- The Plan has first priority for the full amount of benefits it has 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 Plan to exercise the Plan's rights and do nothing to prejudice them.
- The Plan has the right to take whatever legal action it sees 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 Plan's subrogation claim and any claim still held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, other expenses or costs you incur without the Plan's prior written consent. The Plan 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 Plan.

Reimbursement

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

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

- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, it shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
  1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
  2. You fail to cooperate.
- In the event that you fail to disclose to the Plan the amount of your settlement, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your settlement, whichever is less, directly from the Providers to whom the Plan has made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan would not have any obligation to pay the Provider.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify the Plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

Right of Recovery

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

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 Plan)

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

The Employer is responsible for passing information to the Member. For example, if the Plan gives notice to the Employer, it is the Employer's responsibility to pass that information to the Member. The Employer is also responsible for passing eligibility data to the Plan in a timely manner. If the Employer does not provide the Plan with timely enrollment and termination information, the Plan is not responsible for the payment of Covered Services for Members.

Anthem Blue Cross and Blue Shield Note

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Booklet and the Administrative Services Agreement constitutes a contract solely between the Employer and Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (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, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, 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 this agreement.

Conformity with Law

Any provision of this Plan which is in conflict with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Clerical Error

A clerical error will never disturb or affect a Member's coverage, as long as the Member's coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Employer or the Plan.

Policies and Procedures

The Employer is able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules and interpretations.

Under the terms of the Administrative Services Agreement, the Administrator has the authority, in its sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Benefit Booklet. The Administrator reserves the right to discontinue a pilot or test program at any time. The Administrator will provide advance written notice to the Employer of the introduction or termination of any such program.

Medical Policy and Technology Assessment

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

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

Waiver

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

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 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 appeals procedures.

14 DEFINITIONS

If a word or phrase in this Benefit Booklet have special meaning, or is a title, it will start with a capital letter. If the word or phrase is not explained in the text where it appears, it will be defined in this section.

If you need additional clarification on any of these definitions, please contact the customer service number located on the back of your ID Card or submit your question online at www.anthem.com.

Actively At Work - An employee who is capable of carrying out their regular job duties and who is present at their place of work. Additionally, Subscribers who are absent from work due to a health related absence or disability and those on maternity leave or scheduled vacation, are considered Actively At Work.

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.

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

Behavioral Health Services Subcontractor - An organization or entity that the Plan has a contract with to provide administrative and claims payment services and/or Covered Services regarding Behavioral Health services under the Plan. These administrative services may also be provided directly by the Administrator.

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

Benefit Period – The length of time that the Plan will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends before this length of time, then the Benefit Period also ends.

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

Copayment – A specific dollar amount or percentage of Maximum Allowable Amounts for Covered Services indicated in the Schedule of Benefits for which you are responsible. Your flat dollar Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

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 after the

Deductible 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 the Plan.
- 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 this Benefit Booklet.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission except as otherwise specified in benefits after termination.

Covered Services do not include any services or supplies that are not documented in Provider records.

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 myeloblative therapy.

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

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. 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
- 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.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which you must pay for before the Plan will pay for those Covered Services in each Benefit Period.

Dependent – A Member of the Subscriber's family who is covered under the Plan, as described in the "Eligibility and Enrollment" Section.

Diagnostic (Service/Testing) – A test or procedure performed on a Member, who is displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for a Member who is not displaying any symptoms. However, this must be ordered by a Provider. Examples of covered Diagnostic Services 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 that a Subscriber's coverage begins under the Plan. You must be Actively At Work on your Effective Date for your coverage to begin. If you are not Actively At Work on your Effective Date, your Effective Date changes to the date that you do become Actively At Work.

A Dependent's coverage also begins on the Subscriber's Effective Date.

Eligible Person – A person who meets the Employer's requirements and is entitled to apply to be a Subscriber.

Emergency (Emergency Medical Condition) – 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 (Emergency Services) - A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient.

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

Enrollment Date – The day the Employer or Member signs up for coverage or, when there is a waiting period, the first day of the waiting period (normally the date that 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, on behalf of the Employer, determines to be unproven. For how this is determined, see the "Non-Covered Services/Exclusions" section.

Family Coverage – Coverage for the Subscriber and all eligible Dependents.

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

Identification Card / ID Card – A card issued by the Plan, showing the Member's name, membership number, and occasionally coverage information.

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. This does not apply to a Member who is placed under observation for fewer than 24 hours.

Late Enrollee - An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under the Plan, and who did not qualify for Special Enrollment.

Maximum Allowable Amount (Maximum Allowed Amount) – The maximum amount that the Plan will allow for Covered Services you receive. For more information, see the "Claims Payment" section.

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

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Benefit Booklet.

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

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

Member – A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and been covered by the required Fee payment; Members are sometimes called "you" or "your" in this Benefit Booklet.

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

Network Provider - A Provider who has entered into a contractual agreement or is being used by the Administrator, or another organization, which has an agreement with the Administrator, to provide Covered Services and certain administration functions for the Network associated with the Plan.

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

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

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 the Administrator for the Network associated with the Plan. Providers who have not contracted or affiliated with the Plan's designated Subcontractor(s) for the services they perform under the Plan are also considered Non-Network Providers.

Non-Network Transplant Provider - Any Provider that has **NOT** been designated as a "center of excellence" by the Administrator or has not been selected to participate as a Network Transplant Provider by a designee.

Open Enrollment – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; See Eligibility and Enrollment section for more information.

Out of Pocket Limit - A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket

Limit is reached for a Member and/or family, then no additional Deductibles, Coinsurance, and Copayments are required for that person and/or family unless otherwise specified in this Benefit Booklet and/or the Schedule of Benefits.

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

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

Primary Care Physician ("PCP") – A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

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

- **Alcoholism Treatment Facility** - A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **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 facility, with an organized staff of Physicians, that:
  1. Is licensed as such, where required;
  2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  4. Does not provide Inpatient accommodations; and
  5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Certified Advance Registered Nurse Practitioner**
- **Certified Nurse Midwife**
- **Certified Registered Nurse Anesthetist**
- **Certified Surgical Assistant**
- **Day Hospital** - A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility** - A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.
- **Drug Abuse Treatment Facility** - A facility which provides detoxification and/or rehabilitation treatment for drug abuse.
- **Home Health Care Agency** - A facility, licensed in the state in which it is located, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Home Infusion Facility** - A facility which provides a combination of:

  1. Skilled nursing services
  2. Prescription Drugs
  3. Medical supplies and appliances

  in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.
- **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 is 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
  8. Treatment of drug abuse

- **Laboratory (Clinical)**
- **Licensed Practical Nurse**
- **Licensed Professional Counselors**
- **Occupational Therapist**
- **Outpatient Psychiatric Facility** - A facility which mainly provides Diagnostic and therapeutic services for the treatment of Behavioral Health Conditions on an Outpatient basis.
- **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.
- **Physical Therapist**
- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).
- **Psychiatric Hospital** - A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
- **Registered Nurse First Assistant**
- **Registered Nurse**
- **Registered Nurse Practitioner**
- **Regulated Physician's Assistant**
- **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Respiratory Therapist (Certified)**
- **Retail Health Clinic** - A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.
- **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.

- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.
- **Speech Therapist**
- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**
- **Urgent Care Center** - A licensed 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 Plan.

Service Area – The geographical area where the Plan's Covered Services are available.

Single Coverage – Coverage that is limited to the Subscriber only.

Special Enrollment – A period of enrollment in which certain Eligible Persons or their Dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc.

Specialty Care Physician (SCP) - A Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

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; or
- 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 Behavioral Health 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 employee or Member of the Employer who is eligible to receive benefits under the Plan.

Therapy Services – Services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed in the "Covered Services" section.

15 FOR QUESTIONS ABOUT BENEFITS, CLAIMS, ENROLLMENT, OR BILLINGS

CUSTOMER SERVICE NUMBER
Business Hours are 8:00 a.m. to 6:00 p.m.
Medical Questions - 1-877-814-9709

PRECERTIFICATION
1-877-814-4803

MENTAL HEALTH OR SUBSTANCE ABUSE PROGRAM
1-800-223-7723

EMPLOYEE ASSISTANCE PROGRAM
1-800-223-7723

PLEASE HAVE YOUR IDENTIFICATION NUMBER READY WHEN YOU CALL

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
An independent licensee of the Blue Cross and Blue Shield Association.
® Registered marks Blue Cross and Blue Shield Association.

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.

Group Name:	State of Indiana
Group Identification Number:	00083795
Subgroup Identification Number:	

Mail to group.

State of Indiana

compli_prod-80189680-20141205-132550