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Administered by Anthem Insurance Companies, Inc.

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Administered by Anthem Insurance Companies, Inc.



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Your Health Benefit Booklet

Health Benefit Booklet

Blue Access

Indiana State Police Traditional

**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.

1 INTRODUCTION

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

Your Employer has agreed to be subject to the terms and conditions of the Administrator's Provider agreements which may include pre-service review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

This Health Benefit Booklet overrides and replaces any Health Benefit Booklet previously issued to you. 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.

How to Obtain Language Assistance

The Administrator is committed to communicating with Members about their health plan, regardless of their language. The Administrator employs a language line interpretation service for use by all of its Member Services call centers. Simply call the Member Services phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Member Services. TTY/TDD services also are available by dialing 711. A special operator will get in touch with the Administrator to help with your needs.

Identity Protection Services

Identity protection services are available with the Employer's Anthem health plans. To learn more about these services, please visit www.anthem.com/resources.

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 MEMBER RIGHTS AND RESPONSIBILITIES

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

You have the right to:

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

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health Plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP, if your health Plan requires it.

- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call your health care Provider's office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care Providers to make a treatment plan that you all agree on.
- Inform your health care Providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the health care plan that you have agreed on with your health care Providers.
- Give the Administrator, your Doctors and other health care Providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health Plan. This may include information about other health insurance benefits you have along with your coverage with the Plan.
- Inform Member Services if you have any changes to your name, address or family members covered under your Plan.

If you would like more information, have comments, or would like to contact the Administrator, please go to anthem.com and select Customer Support > Contact the Administrator Or call the Member Services number on your ID card.

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

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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.

Under certain circumstances, if the Plan pays the Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, the Plan may collect such amounts directly from you. You agree that the Plan has the right to collect such amounts from you.

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.

DEDUCTIBLE

	Network	Non-Network
Per Member	\$750	\$1,500
Per Family	\$1,500	\$3,000

Note: The Network and Non-Network Deductibles are separate and cannot be combined.

Note: The Deductible applies to all Covered Services with Coinsurance amounts you incur in a Benefit Period, except for the following:

- Emergency Room services when subject to a Copayment plus Coinsurance
- Prescription Drug benefits

Copayments are not subject to and do not apply to the Deductible.

OUT-OF-POCKET LIMIT

	Network	Non-Network
Per Member	\$3,500	\$7,000
Per Family	\$7,000	\$14,000

Note: The Out-of-Pocket Limit includes all Deductibles, Copayments, and Coinsurance amounts you incur in a Benefit Period, except for the following services:

- Non-Network Human Organ and Tissue Transplant services

No one person will pay more than their individual Out-of-Pocket Limit under a Family plan. Once the Member and/or Family Out-of-Pocket Limit is satisfied, no additional Deductibles or Copayments/Coinsurance will be required for the Member and/or Family for the remainder of the Benefit Period, except for the services listed above.

Network and Non-Network Deductibles, Copayments, Coinsurance, and Out-of-Pocket Limits are separate and do not 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 (Ground)	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.
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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 & Substance Abuse Services

- | | | |
|---------------------------------------------------------------------------------------------------|-----------------|-----------------|
| • Inpatient Facility Services | 20% Coinsurance | 40% Coinsurance |
| • Inpatient Professional Services | 20% Coinsurance | 40% Coinsurance |
| • Outpatient Facility Services (Includes Outpatient Hospital / Alternative Care Facility) | 20% Coinsurance | 40% Coinsurance |
| • Outpatient Professional Services | 20% Coinsurance | 40% Coinsurance |
| • Other Outpatient Services | 20% Coinsurance | 40% Coinsurance |
| • Office Visits (Including Online Visits and Intensive In-Home Behavioral Health Programs) | 20% Coinsurance | 40% Coinsurance |

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

Colonoscopy (diagnostic)	No Copayment/Coinsurance up to the Maximum Allowable Amount	40% Coinsurance
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Related services, even billed on same claim, are processed based on place of setting cost share

Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia)	Copayments / Coinsurance based on setting where Covered Services are received.	Copayments / Coinsurance based on setting where Covered Services are received.
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Benefit Maximum for Surgical Treatment and anesthesia for Accidental Dental Services

Covered Services are limited to \$3,000 per Member per accident (Network and Non-Network combined).
 Note: The limit will not apply to Outpatient facility charges, anesthesia billed by a Provider other than, the Physician performing the service, or to services that are required to be covered by law.

Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received.	Copayments/Coinsurance based on setting where Covered Services are received.
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For information on equipment and supplies, see "Medical Supplies, Durable Medical Equipment, and Appliances".

Screenings for gestational diabetes are covered under "Preventive Care."

For information on Prescription Drug coverage, see "Prescription Drugs".

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.	Copayments / Coinsurance based on setting where Covered Services are received.
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Laboratory services provided by a facility participating in the 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 the 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 Copayment / Coinsurance is waived if you are admitted	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.
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Home Care Services	20% Coinsurance	40% Coinsurance
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Maximum Visits per Benefit Period 100 visits, Network and Non-Network combined

Note: Maximum does not apply to Home Infusion Therapy or Private Duty Nursing rendered in the home.

Private Duty Nursing Maximum per Member per Benefit Period	82 visits
Lifetime Maximum	164 visits

Hospice Services	No Copayment / Coinsurance up to the Maximum Allowable Amount	No Copayment / Coinsurance up to the Maximum Allowable Amount. You are responsible for any amounts charged that exceed the Maximum Allowable Amount.
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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)	60 days, combined Network and Non-Network	
Maximum days per Benefit Period for Skilled Nursing Facility	90 days, combined Network and Non-Network	
Mammograms (Outpatient diagnostic & routine)	Please see the "Preventive Care Services" provision in this Schedule.	
Maternity Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Network Pharmacy.)	20% Coinsurance	40% Coinsurance
<p>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.</p> <p>Maximum per Benefit Period One wig per Benefit Period Network and Non-Network for Wigs following cancer treatment</p> <p>Note: If durable medical equipment or appliances are obtained through your PCP/SCP or another Network Physician's office, Urgent Care Center Services, Other Outpatient Services, Home Care Services the Copayment/Coinsurance listed above will apply in addition to the Copayment/Coinsurance in the setting where Covered Services are received.</p>		
Outpatient Services		
Outpatient Surgery Hospital/ Alternative Care Facility	20% Coinsurance	40% Coinsurance

Other Outpatient Services	20% Coinsurance	40% Coinsurance
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Note: Physical Medicine Therapy obtained 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
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Specialty Care Physician (SCP)	20% Coinsurance	40% Coinsurance
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Online Visits (Other than Behavioral Health & Substance Abuse; see Behavioral Health & Substance Abuse Services section for further details)	20% Coinsurance	40% Coinsurance
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Allergy Injections	20% Coinsurance	40% Coinsurance
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Notes: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations covered under "Preventive Care Services" in the Benefit Booklet) 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.	Copayments/Coinsurance based on setting where Covered Services are received
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Surgical Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received
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Maximum for Bariatric Surgery	Unlimited per Lifetime Network and Non-Network combined	
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Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	Copayments/Coinsurance based on setting where Covered Services are received	Copayments/Coinsurance based on setting where Covered Services are received
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Therapy Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received
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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	50 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	50 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	50 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	50 visits, combined Network & Non-Network	
Cardiac Rehabilitation	50 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.	
Pulmonary Rehabilitation	50 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. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	

Urgent Care Center Services	20% Coinsurance	40% Coinsurance
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Allergy injections	20% Coinsurance	40% Coinsurance
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Notes: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs received in an Urgent Care Center 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 Urgent Care Center visit Copayment / Coinsurance will apply if an Urgent Care Center visit is billed with an allergy injection.

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) 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 collection 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 on where the service is performed, subject to applicable Member cost shares.

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

Deductible	Network Provider	Transplant	Non-Network Transplant Provider
	Not Applicable		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 Provider	Transplant	Non-Network Transplant Provider
	<p>During the Transplant Benefit Period, No Copayment / Coinsurance up to the Maximum Allowable Amount</p> <p>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.</p>		<p>During the Transplant Benefit Period, You will pay 50% 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.</p>
			<p>If the Provider is also a Network Provider for the Plan (for services other than Transplant Services and Procedures), then you will not be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount.</p>
			<p>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.</p>
			<p>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.</p>

Covered Transplant Procedure during the Transplant Benefit Period	Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
	No Copayment / Coinsurance up to the Maximum Allowable Amount	You are responsible for 50% of Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	Covered, as approved by the Plan, up to a \$10,000 benefit limit per transplant	Not Covered for Transplants received at a Non-Network Transplant Provider Facility
Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure	Covered, as approved by the Plan, up to a \$30,000 per transplant benefit limit.	Covered, as approved by the Plan, up to a \$30,000 per transplant 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	Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	You will pay 50% of the Maximum Allowable Amount for Medically Necessary live organ donor expenses. These charges will NOT apply to your Out-of-Pocket Limit. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement.

Prescription Drugs

Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Retail Pharmacy (Network and Non-Network) 30 day supply

Mail Service 90 day supply

Prescription Drug Deductible (applies to all tiers for retail, mail order, network and non-network)

Per Person \$200

Note: Network pharmacy is not subject to the medical plan deductible only Rx deductible.

Note: The Prescription Drug Deductible is separate and does not apply toward any other Deductible for Covered Services in this Certificate.

Note: The Rx deductible and copayments do accrue to the medical out-of-pocket limit.

Network Retail Pharmacy Prescription Drug Copayment/Coinsurance:

Tier 1 Prescription Drugs	\$25 Copayment per Prescription Order
Tier 2 Prescription Drugs	\$40 Copayment per Prescription Order
Tier 3 Prescription Drugs	50% Coinsurance per Prescription Order

The PBM's Mail Service Program Prescription Drug Copayment/Coinsurance:

Tier 1 Prescription Drugs	\$30 Copayment per Prescription Order
Tier 2 Prescription Drugs	\$80 Copayment per Prescription Order
Tier 3 Prescription Drugs	50% Coinsurance per Prescription Order

Non-Network Retail Pharmacy Prescription Drug Copayment:

Tier 1 Prescription Drugs	\$25 Copayment plus an additional 20% of remaining cost
Tier 2 Prescription Drugs	\$40 Copayment plus an additional 20% of remaining cost
Tier 3 Prescription Drugs	70% Coinsurance per Prescription Order

Orally Administered Cancer Chemotherapy

No Copayment /Coinsurance will apply to orally administered cancer chemotherapy when obtained from a Network Pharmacy, Mail Service Program, or Specialty Pharmacy Network.

No Copayment /Coinsurance will apply to orally administered cancer chemotherapy obtained from a Non-Network Pharmacy up to the Maximum Allowable Amount; you will be responsible for the amount that exceeds the Maximum Allowable Amount, up to billed charges.

As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.

Note: No Deductible or Copayment / Coinsurance applies to certain diabetic and asthmatic supplies, up to the Maximum Allowable Amount when obtained from a Network Pharmacy. These supplies are covered as medical supplies, durable medical equipment, and appliances if obtained from a Non-Network Pharmacy. Diabetic test strips are covered subject to Prescription Drug Copayments/Coinsurance.

5 COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **To receive maximum benefits for Covered 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

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

Medically Necessary ambulance services are a Covered Service when:

- 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.

And one or more of the following criteria are met:

- For ground ambulance, you are taken:
 - From your home, the scene of an accident or medical Emergency to a Hospital;
 - Between Hospitals, including when the Administrator requires 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 the Administrator requires 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 the Administrator. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Non-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by the Administrator. When using an air ambulance for non-Emergency transportation, the Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance Provider the Administrator selects, 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 the Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

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

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

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

- a) 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 state and 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.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
 - Observation and assessment by a physician weekly or more often,
 - Rehabilitation, therapy, and education.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs and (when available in your area) Intensive In-Home Behavioral Health Services.
- **Online Visits** when available in your area. Covered Services include a visit with the doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or doctor to doctor discussions.

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

- 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 Mental Health Counselor (L.M.H.C.) or
- Any agency licensed by the state to give these services, the Plan has to cover them by law.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, 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 of Health and Human Services 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.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including requests 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; or
- ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

- 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 of 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.
- Genetic tests, when allowed by the Plan.
- 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.
- Electrocardiograms.

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 radiology is performed in a Network Physician's Office, no Copayment is required. Any Coinsurance from a Network or a Non-Network Physician 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. 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 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 and Physician services, and supplies and Prescription Drugs charged by that facility.

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copayment/Coinsurance for that Emergency Room visit will be waived. 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. However, you must obtain Urgent Care services from a Network Provider to receive maximum benefits. Urgent Care Services received from a Non-Network Provider will be covered as a Non-Network service and you will 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.
- When available in your area, benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Behavioral Health and Substance Abuse Services" section.

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, on behalf of the Employer. 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.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

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 postdischarge follow-up to verify the condition of the infant after discharge.
- **Covered Services include at-home post delivery care visits** at your residence by a Physician or Nurse 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 only 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.

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

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 the Plan's Prescription Drug benefit or if the supplies, equipment or appliances are not received from the PBM's Mail Service or from a Network Pharmacy. Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. 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. Needles/syringes
5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

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. medijectors

If you have any questions regarding whether a specific medical or surgical supply is covered, call the Member Services number on the back of your Identification Card.

- **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 Member Services number on the back of your Identification Card.

- **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).
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 Member Services number on the back of your Identification Card.

- **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 Member Services number on the back of your Identification Card.

- **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.

Online visits. When available in your area, your coverage will include online visit services. Covered Services include a medical consultation using the internet via a webcam, chat or voice. For Behavioral Health and Substance Abuse Online Visits, see the "Behavioral Health and Substance Abuse Services" section. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. Non Covered Services include, but are not limited to, communications used for:

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

Preventive Care Services

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

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA). This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use a Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the “Diagnostic Services” benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

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;
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. Women’s contraceptives, sterilization procedures, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered as Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the Prescription Drug benefit.
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
 - c. Gestational diabetes screening.
5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
 - a. Counseling
 - b. Prescription Drugs
 - c. Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

- a. Aspirin
- b. Folic acid supplement
- c. Vitamin D supplement
- d. Bowel preparations

Please note that certain age and gender and quantity limitations apply.

You may call Member Services 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/.](http://www.cdc.gov/vaccines/recs/acip/))

Covered Services also include the following services:

- 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 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.

Surgical Treatment for Morbid Obesity may be limited. See the Schedule of Benefits.

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.

They are covered if provided within the Plan's guidelines.

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; adaptations 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 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.

Vision Services

Benefits are available for medical and surgical treatment of injuries and/or diseases affecting the eye. Vision screenings required by federal law are covered under the "Preventive Care" benefit. Benefits for other Covered Services are based on the setting in which services are received.

Benefits are not available for glasses and contact lenses except as described in the "Prosthetics" benefit.

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) 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 collection 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 stem cell / bone marrow transplants and transfusions as determined by the Administrator including necessary acquisition procedures, collection 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 case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Case Manager for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility or

starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Network Transplant Provider Facility.

Prior Approval and Precertification

In order to maximize your benefits, the Administrator strongly encourages you to call its transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. The Administrator will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Member Services telephone number on the back of your Identification Card **and ask for the transplant coordinator**. Even if the Administrator 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 Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the 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.

For lodging and ground transportation benefits, the Plan will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by the Administrator,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,

- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Interim visits to a medical care facility while waiting for the actual transplant procedure,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

Prescription Drug Benefits

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

Pharmacy Benefits Manager

Your plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. The pharmacy benefits available to you under the Plan are managed by the Administrator's Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which the Administrator contracts to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Home Delivery (Mail Service) pharmacy, and provides clinical management services.

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

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

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

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network

pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The PBM uses pre-approved criteria, developed by the Administrator's Pharmacy and Therapeutics Committee which is reviewed and adopted by the Administrator. The Administrator or the PBM may contact your Provider if additional information is required to determine whether Prior Authorization should be granted. The Administrator communicates the results of the decision to both you and your Provider.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the Your Right To Appeal section of this Benefit Booklet.

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

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

Step Therapy

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

Covered Prescription Drug Benefits

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Benefits are available for the following:

- Prescription Legend Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs, injectable contraceptive drugs and patches are covered when obtained through an eligible Pharmacy. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/Coinsurance. Contact the Administrator to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Injectables.
- Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. Benefits include approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These services will be covered under the “Preventive Care” benefit. Please see that section for further details.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.
- Immunizations (including administration) required by the “Preventive Care” benefit.
- Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved as designated in the FDA’s Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

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

- Prescription Drugs dispensed by any Mail Service program other than the PBM’s Mail Service, unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product may not be covered, even if written as a Prescription. This Exclusion does not apply to over-the-counter products that the Plan must cover as a “Preventive Care” benefit under federal law with a Prescription.
- Off label use, except as otherwise prohibited by law or as approved by the Administrator or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.

- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs which are over any quantity or age limits set by the Plan.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Drugs in quantities which exceed the limits established by the Plan.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Compound Drugs all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- Treatment of Onychomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. **Please contact the Administrator for additional information on these Drugs.**
- Refills of lost or stolen medications.
- Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by the Plan's Administrator.
- Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- Charges for services not described in your medical records.
- Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- Services Plan concludes are not Medically Necessary. This includes services that do not meet the Administrator's medical policy, clinical coverage, or benefit policy guidelines.

- Nutritional and/or dietary supplements, except as described in this Benefit Booklet or that the Plan must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- Any Drug, Drug regimen, treatment, or supply that is furnished, ordered or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies.

Deductible/Coinsurance/Copayment

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

Days Supply

The number of days supply of a Drug which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days supply allowed for under this Benefit Booklet, you should ask your Pharmacist to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Member Services telephone number on the back of your Identification Card.

Tiers

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug has been classified by the Plan as a first, second, or third “tier” Drug. The determination of tiers is made by the Administrator, on behalf of the Employer, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

- **Tier 1** Prescription Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred medications that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- **Tier 2** Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred medications that may be Generic, single source, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- **Tier 3** Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.

Tier and Formulary Assignment Process

The Administrator has established a National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists, and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs; determining the tier assignments of drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determinations of tier assignments and formulary inclusion are made by the Administrator based upon clinical decisions provided by the National P&T Committee, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one Drug over another in the Administrator's patient population, and where appropriate, certain clinical economic factors.

Benefits may not be covered for certain Drugs if they are not on the formulary. You can get a copy of the formulary by calling the Administrator or visiting its' website at www.anthem.com. If you or your doctor believes you need to use a Prescription Drug not on the formulary, please have them get in touch with the Administrator. The Plan will cover the Prescription Drug only if the Administrator agrees that it is Medically Necessary and appropriate over the other Drugs on the formulary. The Administrator will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

The Plan retains the right at its discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example, oral, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted Prescription Drugs if your Prescription Drugs or dose changes between fills, by allowing only a portion of your prescription to be filled at the specialty pharmacy. This program also saves you out of pocket expenses. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these Prescription Drugs by calling the toll-free number on your member ID card or log on to the website at www.anthem.com.

Special Programs

Except when prohibited by federal regulations (such as HSA rules), from time to time the Administrator may initiate various programs to encourage the use of more cost-effective or clinically-effective Prescription Drugs including, but not limited to, Generic Drugs, Mail Service Drugs, over the counter or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain Drugs or preferred products for a limited period of time.

Half-Tablet Program

The Half-Tablet Program will allow Members to pay a reduced Copayment on selected "once daily dosage" medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of

the higher strength medication when written by the Physician to take “ $\frac{1}{2}$ tablet daily” of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member’s decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact the number on the back of your ID Card.

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, a Non-Network Pharmacy, or the PBM’s Mail Service Program. It is also based upon which Tier the Administrator has classified the Prescription Drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

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

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

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

How to Obtain Prescription Drug Benefits

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

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

Important Note: If the Plan determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, the Plan may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single Network Pharmacy. The Administrator will contact you if it is determined that use of a single Network Pharmacy is needed and give you options as to which Network Pharmacy you may use. If you do not select one of the Network Pharmacies offered within 31 days, a single Network Pharmacy will be selected for you. If you disagree with the Plan’s decision, you may ask the Plan to reconsider it as outlined in the “Your Right To Appeal” section of this Benefit Booklet.

In addition, if the Plan determines that you may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Providers for Controlled Substance Prescriptions may be limited. If this happens, the Plan may require you to select a single Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if you use the single Network Provider. The Administrator will contact you if it is determined that use of a single Network Provider is needed and give you options as to which Network Provider you may use. If you do not select one of the Network

Providers offered within 31 days, the Plan will select a single Network Provider for you. If you disagree with the Plan's decision, you may ask for reconsideration it as outlined in the "Your Right To Appeal" section of this Benefit Booklet.

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

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

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

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

6 NON-COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

The Plan does not provide benefits for procedures, equipment, services, supplies or charges:

1. Which the Administrator, on behalf of the Employer, determines are not Medically Necessary or do not meet the Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

2. Received from an individual or entity that is not licensed by law to provide Covered Services as defined in this Benefit Booklet. Examples may include masseurs or masseuses (massage therapists) and physical therapist technicians.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Administrator, on behalf of the Employer. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if the Administrator deems it to be Experimental/Investigative. Details on the criteria used to determine if a service is Experimental/Investigative is outlined below.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, unless otherwise required by law or regulation.
9. For court ordered testing or care unless Medically Necessary.
10. For which you have no legal obligation to pay in the absence of this or like coverage.
11. For the following:
 - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member, except as otherwise described in this Benefit Booklet.
 - Surcharges for furnishing and/or receiving medical records and reports.
 - Charges for doing research with Providers not directly responsible for your care.
 - Charges that are not documented in Provider records.
 - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
 - For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

12. 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.
13. 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.
14. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
15. For missed or canceled appointments.
16. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by the Administrator or specifically stated as a Covered Service.
17. Charges in excess of the Plan's Maximum Allowable Amounts.
18. Incurred prior to your Effective Date.
19. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
20. For any procedures, services, Prescription Drugs, 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 social 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). Complications directly related to cosmetic services treatment or surgery, as determined by the Administrator, on behalf of the Employer, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
21. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
22. For the following:
 - Custodial Care, convalescent care or rest cures.
 - Domiciliary care provided in a residential institution, treatment center, supervised living or 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.
 - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, halfway house, or outward bound programs, even if psychotherapy is included.

- Wilderness camps.
23. For 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:
 - cleaning and soaking the feet.
 - applying skin creams in order to maintain skin tone.
 - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
 24. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
 25. For dental treatment, regardless of origin or cause, except as specified elsewhere in this Benefit Booklet. "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) or gums, including but not limited to:
 - extraction, restoration and replacement of teeth.
 - medical or surgical treatments of dental conditions.
 - services to improve dental clinical outcomes.
 26. For 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.
 27. For Dental implants.
 28. For Dental braces.
 29. For 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:
 - transplant preparation.
 - initiation of immunosuppressives.
 - direct treatment of acute traumatic injury, cancer or cleft palate.
 30. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
 31. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Benefit Booklet. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity.
 32. For marital counseling.
 33. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition.

34. For routine vision screenings not required by federal law as described in the "Preventive Care" benefit.
35. For vision orthoptic training.
36. For hearing aids or examinations for prescribing or fitting them.
37. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
38. For services to reverse voluntarily induced sterility.
39. For diagnostic testing or treatment related to infertility
40. For personal hygiene, environmental control, or convenience items including but not limited to:
 - Air conditioners, humidifiers, air purifiers;
 - 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 non-medical self-care except as otherwise stated;
 - Purchase or rental of supplies for common household use, such as water purifiers;
 - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
 - Infant helmets to treat positional plagiocephaly;
 - Safety helmets for Members with neuromuscular diseases; or
 - Sports helmets.
41. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
42. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, authorized by the the Plan, or as otherwise described in this Benefit Booklet.
43. For care received in an emergency room which is not Emergency Care, except as specified in this Benefit Booklet. This includes, but is not limited to suture removal. For non-Emergency Care please use the closest Network Urgent Care Center and/or your Primary Care Physician for services.
44. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.
45. For self-help training and other forms of non-medical self care, except as otherwise provided herein.
46. For examinations relating to research screenings.
47. For stand-by charges of a Physician.
48. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, which are not required by law under the "Preventive Care" benefit.

49. For 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 the "Covered Services" section.
50. For Manipulation Therapy services rendered in the home as part of Home Care Services.
51. Services and supplies related to 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.
52. For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.
53. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, and electromagnetic therapy.
54. For any services or supplies provided to a person not covered under the Benefit Booklet in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
55. For surgical treatment of gynecomastia.
56. For treatment of hyperhidrosis (excessive sweating).
57. For any service for which you are responsible under the terms of this Benefit Booklet to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.
58. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Administrator, on behalf of the Employer, through Prior Authorization.
59. Complications of, or services directly related to a service, supply, or treatment that is a non Covered Service under the Plan because it was determined by the Administrator, on behalf of the Employer, to be Experimental/Investigational or non Medically Necessary. Directly related means that the service, supply, or treatment occurred as a direct result of the Experimental/Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non Medically Necessary service.
60. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply may not be covered even if written as a Prescription. This Exclusion does not apply to over-the-counter products that the Plan must cover as a "Preventive Care" benefit under federal law with a Prescription.
61. Treatment of telangiectatic dermal veins (spider veins) by any method.
62. Reconstructive services except as specifically stated in the **Covered Services** section of this Benefit Booklet, or as required by law.

63. For non-preventive medical nutritional therapy from a Non-Network Provider.
64. For room and board charges unless the treatment provided meets the Administrator's Medical Necessity criteria for Inpatient admission for your condition.
65. Nutritional and/or dietary supplements, except as provided in this Benefit Booklet or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
66. Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center.
67. Charges for delivery of Prescription Drugs.
68. Drugs in quantities which are over the limits set by the plan, or which are over any age limits set by the Plan.
69. Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
70. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by the Plan.
71. For drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
72. For drugs not on the Administrator's Prescription Drug List (a formulary). You can get a copy of the list by calling the Administrator or visiting its website at www.anthem.com.
73. Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
74. Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
75. Refills of lost or stolen Drugs.
76. Off label use, unless the Plan must cover it by law or if the Plan approves it.
77. Any service, Drug, Drug regimen, treatment, or supply, furnished, ordered, or prescribed by a Provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to Emergency Care.

EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION

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 in its sole discretion to be Experimental/Investigative is not covered under the Plan.

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

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

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

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

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

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Administrator, on behalf of the Employer, 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.

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

Employees All active full-time Indiana State Police employees regularly scheduled to work not less than 37 $\frac{1}{2}$ hours per week are eligible, as are disabled employees, their spouses and their eligible "Dependents".

An eligible Dependent of an employee becomes eligible for coverage on the effective date of the employee's coverage.

If a Dependent, other than a newborn infant of an Enrollee, is confined in a hospital on the date his or her coverage would otherwise begin, his or her coverage will become effective upon final medical release from such confinement.

Retirees A retiree becomes eligible for coverage either: 1) the month he or she retires (if the retirement becomes effective on the first day of that month); or 2) the first day of the month following the date retirement becomes effective, if he or she:

- Has completed 25 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or
- Is age 65, has completed 10 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or
- Is age 60, has completed 15 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or

- Is age 55, age plus years of Creditable Service equals 85 or more, and is immediately eligible for an unreduced pension benefit.

Additional eligibility requirements for retiree coverage:

Employees hired prior to December 31, 2010 must be enrolled in the Indiana State Police Health Care, Vision and Dental Plan by no later than January 1, 2011 and maintain continuous coverage from that date to date of separation of employment with the Department. Enrollment of an active full-time employee as a Dependent on a Spouse's plan who is an active Eligible Person under this Plan constitutes Creditable Coverage under this provision.

Employees hired after December 31, 2010 must be enrolled in the Indiana State Police Health Care, Vision and Dental Plan within the first 30 days of employment and maintain continuous coverage from that date to date of separation of employment with the Department. Enrollment of an active full-time employee as a Dependent on a Spouse's plan who is an active Eligible Person under this Plan constitutes Creditable Coverage under this provision.

Employees hired on or after July 1, 2016, who are eligible and elect retiree coverage at the time of their separation of employment, will be able to carry retiree coverage for themselves and any eligible dependent(s) until the date the retiree reaches age 65 (Medicare eligible). When the retiree reaches age 65, coverage will cease for the retiree and any covered dependents.

A retiree must elect coverage on the first day he or she becomes eligible, or within 30 days of the eligibility date. Late entrants (after the 30 day period) will be denied coverage. Reentry into the plan after a lapse or termination in coverage will not be permitted.

Premium contributions for retirees covered under the Indiana State Police Pension Fund are paid directly to the Administrator by monthly coupon billing or by deduction from the pension check. All retirees covered by PERF must be coupon billed.

The Retiree Basic Plan includes only Medical and Prescription Drug coverage. The Retiree Optional Plan includes Medical, Prescription Drug, Vision and Dental coverage.

Retirees upgrading from the Basic Plan to the Optional Plan must maintain the upgraded coverage for a period of not less than three years before reducing coverage.

Dependents A Dependent becomes eligible for coverage on the effective date of the Eligible Person's coverage.

"Dependent" – The following persons, provided coverage under the plan is in effect:

- The Eligible Person's spouse.
- Any of the following who qualify as the Eligible Person's Dependent(s), until they reach the limiting age:
 1. Children;
 2. Stepchildren;
 3. Adopted children of the Eligible Person or spouse, from the earlier of: (a) the date of placement for the purpose of adoption; (b) the date of entry of a court order granting the adoptive parent custody of the child for adoption; or

4. Children for whom the Eligible Person or spouse has legal guardianship when both parents of the child are deceased and one of the parents of the child is a member of the Enrollee's immediate family provided the child resides with the Eligible Person or spouse except in those cases when the child is no longer a same household resident while a full time student at an accredited educational institution.
5. Those Dependents enrolled through guardianship prior to July 1, 2000 will remain covered Dependents until the earlier of:
 - a. The Dependent reaches the Dependent limiting age: or
 - b. The Enrollee is no longer the legal guardian of the Dependent: or
 - c. The Enrollee terminates coverage of the Dependent for any reason. In this occurrence, any reinstatement of coverage for the Dependent will be subject to the requirements of the insurance plan for the department then in effect.
- In the event a child who is a "Dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the Enrollee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the Dependent Limiting Age is reached. Coverage for the "Dependent" will continue until the Enrollee discontinues his coverage or the disability no longer exists. The department may require, at reasonable intervals, but no more often than once a year, satisfactory evidence of the disability is continuing.

"Dependent Limiting Age" is the end of the month in which the child attains age 26.

Family Security

If an employee or retiree is covered under this program at the time of his or her death, his or her Dependents, including spouse, who are also covered will be eligible to remain covered under this Plan under the Family Security Program, without payment of premium for a period of three (3) months, or until the occurrence of one of the following events, whichever is earliest:

- The date of remarriage of the surviving spouse, if any; or
- The date a Dependent ceases to meet this Plan's definition of a Dependent.

After the Family Security Program has terminated, the remaining covered Dependents may continue their coverage at the appropriate Dependent premium rate based on the retiree rate structure. Election to continue coverage must be made within 30 days of the notification of the end of the Family Security Program. Coverage elected will become effective on the first day of the month, three months following the Enrollee's death. Late entrants (after the 30-day period) will be denied coverage. Reentry into the plan after a lapse or termination in coverage will not be permitted.

Coverage for a surviving spouse will cease on the earlier of:

- The date or remarriage of the surviving spouse; or
- The date the surviving spouse dies.

Any coverage which is continued for dependent children because of the death of a covered employee or retiree will not cease because of the death of the surviving spouse within the six (6) month period following the date of the employee's or retiree's death.

The dependent benefits payable after the death of the employee or retiree will be those in effect for the dependents on the day prior to the death of the employee or retiree.

Line of Duty

Dependents, including spouses, of employees killed in the Line of Duty shall be offered health insurance coverage in accordance with IC 5-10-14. This coverage will be paid for by the Department. Dependents' coverage is subject to the Eligibility requirements of the Plan.

A surviving spouse may add additional dependents to the Plan that are acquired after the line of duty death. These Dependents are subject to the eligibility requirements of the Plan, and the premium will be based on the retiree rate structure, as follows:

One Dependent – Dependent Only rate.

Two Dependents – Retiree plus One Dependent rate.

Three or more Dependents – Retiree plus Multiple Dependents rate.

Enrollment

Participation in the plan(s) is voluntary, and employees may enroll as follows:

- New employees are given thirty-one (31) days from their date of hire to enroll in any of the programs offered by the Indiana State Police. Coverage becomes effective on the date they elect coverage by signing an approved payroll deduction form. Coverage for Dependents takes effect when the employee becomes covered.
- Dependents born or acquired after the date of enrollment must be added by completion of the appropriate forms within thirty-one (31) days of the marriage, birth, etc.
- Enrollment or changes not in accordance with above paragraphs may be made as follows:
 1. During designated open enrollment periods;
 2. Based upon the evidence of insurability policy under the TPA;
 3. Based on the qualifying events interim in the IRS Code Section 125.

Newborn Infant Coverage

The benefits payable for eligible Dependent children shall be paid for a sick or injured newborn infant of an Eligible Person for the first 31 days of his or her life. The coverage for newly adopted children will be the same as for other Eligible 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:

1. 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;
2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or
3. Continues unless required action as described below is taken.

Single Policy

To be covered beyond the first 31 days on a single policy, the newborn must be added to the Enrollee's plan membership. **The Enrollee will need to contact the Human Resources Division to obtain the appropriate enrollment forms.** The Enrollee will be liable for the higher premium for the entire pay period in which the child was added.

Family Policy

The Administrator will automatically add a newborn child to an existing family membership. The Administrator will send a notice to the Enrollee that an enrollment form must be completed with the child's name. **The Enrollee will need to contact the Human Resources Division to obtain the enrollment form.**

Note: This procedure does not apply in cases of:

- Adoption
- Marriage
- Divorce
- Guardianship

In these cases, you must contact the Human Resources Division to obtain the appropriate enrollment forms.

Qualified Medical Child Support Order/Court Ordered Health Coverage

If you are required by a qualified medical child support order or court order, as defined applicable state or federal law, to enroll your child under this Plan, the State will permit your child to enroll at any time without regard to any open enrollment limits and shall provide the benefits of this Plan in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Plan will be paid, at the Administrator's discretion, on behalf of the State, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The Plan will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Administrator directly.

Contributions

Persons who have elected coverage under the medical, vision and dental plans must authorize payroll deductions to pay their portion of the cost.

Applications

To obtain coverage with the Indiana State Police Health Care Benefit Plan, an Eligible Person must complete and submit an application to the Indiana State Police Human Resources Division. Acceptance of the application is shown by delivery of an identification card showing the Eligible Person's name and identification number.

8 CHANGES IN COVERAGE: TERMINATION & CONTINUATION

Termination

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Employer's specific requirements:

- If you terminate your coverage, termination for Enrollees and Dependents will generally be effective on the earliest of:
 - The date the Administrative Service Agreement or Plan is terminated; or
 - The date the payroll deduction authorization is withdrawn; or
 - The date the premiums are due and payable and unpaid; or
 - Termination of employment (except when retiree coverage is elected); or
 - The date a Dependent ceases to be eligible as defined.
- Subject to any applicable continuation requirements, if you cease to meet eligibility requirements as outlined in this Benefit Booklet, your coverage will terminate on the last day of the billing period. If you cease to be eligible due to termination of employment, your coverage will terminate on the last day of the billing period. You must notify your Employer immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying the Plan for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Fees paid for such services.

- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowable Amount for services received through such misuse.

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 31 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 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.)

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,
- Tell them the reason for your visit.
- When you go to the office, be sure to bring your Member Identification Card with you. The doctor's office may ask you for your group or Member ID number.
- 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 Member Services 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 Member Services before you get services for more information.

If you need details about a Provider's license or training, or help choosing a doctor who is right for you, call the Member Services 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 are 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 Arrangements 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 Member Services 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 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.

For Covered Services rendered outside Anthem's Service Area by Non-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Administrator would use if the healthcare services had been obtained within the Administrator's Service Area, or a special negotiated price.

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 Member Services for help in finding a Network Provider or visit the Administrator's website at www.anthem.com.

Member Services 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 Member Services 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 Benefit Booklet for your cost share responsibilities and limitations, or call Member Services 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 Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain Prescription Drug purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Administrator. These amounts will not be applied to your Deductible, if any, or taken into account in determining your Copayment or Coinsurance.

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 Member Services 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 has 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

The Plan will make benefit payments directly to Network Providers for Covered Services. If you use a Non-Network Provider, however, the Plan may make benefit payments to you or the Non-Network Provider at its discretion. 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, 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.

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'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.

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 Member Services 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, Worker's Compensation or any other governmental program. Any Member who fails to cooperate 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.

Inter-Plan Arrangements

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you access healthcare services outside the geographic area Anthem serves (the “Anthem Service Area”), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some Providers (“nonparticipating providers”) don’t contract with the Host Blue. Explained below is how the Plan pays both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard[®] Program

Under the BlueCard[®] Program, when you receive Covered Services within the geographic area served by a Host Blue, Anthem will still fulfill its contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for 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 the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Plan used for your claim because they will not be applied after a claim has already been paid.

B. Special Cases: Value-Based Programs

BlueCard[®] Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside Anthem's Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. Exceptions

In certain situations, Anthem may use other pricing methods, such as billed charges or the pricing Anthem would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment the Plan makes for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global Core[®] Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

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

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

Please refer to the Health Care Management section in this Benefit Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

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

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

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

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

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

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

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

11 HEALTH CARE MANAGEMENT

Your plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Benefit Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care.

Certain Services must be reviewed to determine Medical Necessity in order for you to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. The Administrator may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost effective is available and appropriate.

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

Coverage for or payment of the service or treatment reviewed is not guaranteed even if it is decide your services are Medically Necessary. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. Fees must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your plan;
4. The service cannot be subject to an Exclusion under your plan; and
5. You must not have exceeded any applicable limits under your plan.

Types of Review:

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.

Precertification – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Benefit Booklet.

For admissions following Emergency Care, you, your authorized representative or Physician must tell 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 needed unless there is a problem and/or the mother and baby are not sent home at the same time. Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

- **Continued Stay / Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay / Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any Physician with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the Administrator has a related clinical coverage guideline and are typically initiated by the Administrator.

Typically, Network Providers know which services require Precertification when needed. 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. Generally, the ordering Provider, facility or attending Physician (“requesting Provider”) will contact the Administrator to request a Precertification. However, you may request a Precertification or 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. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Network	Provider	<ul style="list-style-type: none"> • The Provider must get Precertification when required.
Non Network / Non-Participating	Member	<ul style="list-style-type: none"> • Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.
Blue Card Provider	Member (Except for Inpatient Admissions)	<ul style="list-style-type: none"> • Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. • Blue Card Providers must obtain precertification for all Inpatient Admissions.
<p>NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Physician must tell the Administrator within 48 hours of the admission or as soon as possible within a reasonable period of time.</p>		

How Decisions are Made

The Administrator will utilize its' clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to assist the Plan in making Medical Necessity decisions. This includes decisions about Prescription Drugs. 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.

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.

If you are not satisfied with the Plan's decision under this section of your benefits, please refer to the "Your Right to Appeal" section to see what rights may be available to you.

Decision and Notification Requirements

Timeframes and requirements listed are based on federal regulations. If you reside and/or receive services in a state other than the state where your contract was issued other state-specific Health Care Management requirements may apply. You may call the telephone number on the back of your membership card for additional information.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours or 2 business days from the receipt of all necessary information whichever is less
Non-Urgent Pre-service Review	2 business days from the receipt of all necessary information
Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of all necessary information
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request or 2 business days from the receipt of all necessary information whichever is less
Non-urgent Continued Stay / Concurrent Review for ongoing outpatient treatment	2 business days from the receipt of all necessary information
Post-Service Review	2 business days from the receipt of all necessary information

If additional information is needed to make a decision, the Administrator will notify the requesting Provider of the specific information necessary to complete the review. If the Administrator does not receive the specific information requested by the required timeframe, a decision will be made based upon the information in the Administrator's possession.

The Administrator will notify you and your Provider of a decision in accordance with federal regulations. Notification may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

Upon the recommendation of the Administrator, the Plan may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if in its sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

The Plan may also select certain qualifying Providers to take part in a program or a Provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. The Plan may also exempt your claim from medical review if certain conditions apply.

Just because the Plan exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that the Plan will do so in the future, or will do so in the future for any

other Provider, claim or Member. The Plan may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by contacting the Member Services 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 Plan 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.

Health Plan Individual Case Management

The Administrator's health plan individual 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. The Plan may also extend Covered Services beyond the Benefit Maximums of this Plan. The Administrator 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 you and the Plan and you or your authorized representative agree to the alternate or extended benefit in writing. 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 or

retailer coupons, which you are encouraged to use for health and wellness related activities or items. 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 also be offered a home visit appointment to collect such specimens and complete biometric screenings. 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 have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, the Administrator recommends that you consult your tax advisor.)

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 Member Services 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;
- 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 an 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.

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.

13 GENERAL PROVISIONS

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire agreement 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 Member Services 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 Medicare, 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 not 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.
7. Any amounts incurred or claims made under the Prescription Drug program of This Plan.

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 and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services.

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 payer. 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 from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

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

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset.
- Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
 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 the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred, all information regarding the parties involved and any other information requested by the Plan.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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

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

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

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

Right of Recovery and Adjustment

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

The Administrator has oversight responsibility of compliance with Provider and vendor contracts. The Administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, the Administrator has established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. The Administrator will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

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.

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.

Payment Innovation Programs

The Administrator pays Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by the Administrator from time to time, but they will be generally designed to tie a certain portion of a Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to the Administrator under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect Your access to health care. The Program payments are not made as payment for specific Covered Services provided to You, but instead, are based on the Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by or to the Administrator under the Program(s), and You do not share in any payments made by Network Providers to the Administrator under the Program(s).

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.

Care Coordination

The Administrator pays Network Providers in various ways to provide Covered Services to You. For example, sometimes the Administrator may pay Network Providers a separate amount for each Covered Service they provide. The Administrator may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, the Administrator may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, the Administrator may pay Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Network Providers for coordination of Member care. In some instances, Network Providers may be required to make payment to the Administrator because they did not meet certain standards. You do not share in any payments made by Network Providers to the Administrator under these programs.

Program Incentives

The Plan may offer incentives from time to time, at its discretion, in order to introduce you to covered programs and services. The purpose of these incentives include, but is not limited to, making you aware

of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares.

Acceptance of these incentives is voluntary as long as the Plan offers the incentives program. The Plan may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, it is recommended that you consult your tax advisor.

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.

14 DEFINITIONS

If a word or phrase in this Benefit Booklet has 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 Member Services number located on the back of your ID Card or submit your question online at www.anthem.com.

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.

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.

Biosimilar/Biosimilars - A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Brand Name Drug – Prescription Drugs that the Administrator classifies as Brand Drugs or the Administrator's PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Controlled Substances - Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

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 myeloblastic therapy.

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

Creditable Service- Creditable Years of Service for purposes of eligibility for Retirement coverage under this Plan, means years of service with Indiana State Police or years of service in accordance with IC 5-10-8-6.5.

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 are listed in the Covered Services section.

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

Effective Date – The date that a Subscriber's coverage begins under the Plan. 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 or behavioral health 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 layperson who possesses an average knowledge of health and medicine to:

- place an individual's health or the health of another person 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 or behavioral health 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 or behavioral health examinations 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.

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

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

Generic Drugs – Prescription Drugs that the Administrator classifies as Generic Drugs or that the Administrator’s PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

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.

Intensive In-Home Behavioral Health Program - A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program - Short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Interchangeable Biologic Product - A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

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.

Mail Service – The Anthem Prescription Management program which offers you a convenient means of obtaining maintenance medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with the Administrator, and sent directly to your home.

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. A Provider that is in the Network for one plan may not be in the Network for another. Please see “How to Find a Provider in the Network” in the section “How To Obtain Covered Services” for more information on how to find a Network Provider for this 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 the Blue Cross and Blue Shield Association. 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.

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 the Blue Cross and Blue Shield Association.

Open Enrollment - A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll 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.

Partial Hospitalization Program - Structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy and Therapeutics (P&T) Process (Committee) - A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Physicians. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. The Administrator's programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

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

Prescription Order - A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

Prescription Legend Drug, Prescription Drug, or Drug (also referred to as Legend Drug) - A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA-approved, as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations* require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.

- Insulin.

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.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the P&T Committee.

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.
- **Athletic Trainer** – A person licensed under applicable Indiana state law providing physical medicine and rehabilitative services within their scope of practice.
- **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.
- **Facility** - A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Benefit Booklet. The Facility must be licensed, accredited, registered or approved by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Administrator.
- **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 appliancesin 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.

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. Subacute care

- **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.

- **Residential Treatment Center / Facility** - A Provider licensed and operated as required by law, which includes:

1. Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
2. A staff with one or more Physicians available at all times.
3. Residential treatment takes place in a structured facility-based setting.
4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5. Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
6. Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA)

The term Residential Treatment Center/Facility 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

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

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.

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 Member Services 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.

Utilization Review - Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, procedures, and/or facilities.

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Administered by Anthem Insurance Companies, Inc.

Your Dental Benefit Booklet

Dental Benefit Booklet

Indiana State Police

administered by:

Anthem Insurance Companies, Inc.

120 Monument Circle

Indianapolis, Indiana 46204

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.

1 BENEFIT BOOKLET

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

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

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

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

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

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2 SCHEDULE OF BENEFITS - DENTAL

The Schedule of Benefits is a summary of the amount of benefits the Contractor will pay when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific dental services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Benefit Booklet including any attachments or riders. Benefits for Covered Services are based on the Maximum Allowable Amount. You may be responsible for any balance due between the Provider’s charge and the Maximum Allowable Amount in addition to any Coinsurance, Deductibles, and non-Covered Charges.

Benefit Period	Calendar Year
Dependent Age Limit	To the end of the month in which the child attains age 26
Dental Deductible	
Per Person	\$50
Per Family	\$150
Maximum Per Benefit Period	
For all Dental Services except extraction of impacted or partially impacted teeth and Orthodontia.	\$1,500
For extraction of impacted or partially impacted teeth including anesthesia.	\$2,000
Orthodontic Lifetime Maximum	\$2,500
Covered Services	Coinsurance/Maximums
Class I - Preventive and Diagnostic Covered Services (Not subject to the Deductible)	100% of billed charges
The following services are subject to the Deductible:	
Class II - Restorative Covered Services	90% of billed charges
Class III - Prosthodontics Covered Services	70% of billed charges
Class IV - Orthodontic Covered Services	70% of billed charges

3 DEFINITIONS

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

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 Plan with regard to such Subscriber.

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.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

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

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

Coinsurance - The percentage of Covered Charges for which you are responsible under the terms of this Plan. Coinsurance takes effect after any Dental Deductible is met.

Covered Charges - Charges for Covered Services to the extent that, in the Plan's judgment, such charges are not excessive. This judgment will be based on professional medical opinion or upon the Maximum Allowable Amount for similar providers who perform like Covered Services.

Covered Services - Services, supplies or treatment as described in this Benefit Booklet which are performed, prescribed, directed or

authorized by a Provider. To be considered Covered Services, services must be:

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Plan is in force;
- Within the Maximum Allowable Amount;
- Not specifically excluded or limited by the Plan; and
- Specifically included as a benefit within this Benefit Booklet.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Plan as described in the **Eligibility and Enrollment** section.

Dental Deductible - The specified dollar amount of Covered Charges, stated in the Schedule of Benefits, which you must incur before the Plan begins to pay benefits which are subject to the Dental Deductible.

Effective Date - The date that a Subscriber's coverage begins under the Plan. 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.

Employer - The legal entity contracting with the Administrator for administration of group dental 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).

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

Grievance - Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the

reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Administrator on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- the availability of Providers;
- the handling or payment of claims for dental care services;
- matters pertaining to the contractual relationship between you and the Employer or the Administrator and the Employer.

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

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.

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.

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

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.

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.

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

Subscriber - An employee or Member of the Employer who is eligible to receive benefits under the Plan.

4 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

Employees All active full-time Indiana State Police employees regularly scheduled to work not less than 37 $\frac{1}{2}$ hours per week are eligible, as are disabled employees, their spouses and their eligible "Dependents".

An eligible Dependent of an employee becomes eligible for coverage on the effective date of the employee's coverage.

If a Dependent, other than a newborn infant of an Enrollee, is confined in a hospital on the date his or her coverage would otherwise begin, his or her coverage will become effective upon final medical release from such confinement.

Retirees A retiree becomes eligible for coverage either: 1) the month he or she retires (if the retirement becomes effective on the first day of that month); or 2) the first day of the month following the date retirement becomes effective, if he or she:

- Has completed 25 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or
- Is age 65, has completed 10 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or
- Is age 60, has completed 15 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or
- Is age 55, age plus years of Creditable Service equals 85 or more, and is immediately eligible for an unreduced pension benefit.

Additional eligibility requirements for retiree coverage:

Employees hired prior to December 31, 2010 must be enrolled in the Indiana State Police Health Care, Vision and Dental Plan by no later than January 1, 2011 and maintain continuous coverage from that date to date of separation of employment with the Department. Enrollment of an active full-time employee as a Dependent on a Spouse's plan who is an active Eligible Person under this Plan constitutes Creditable Coverage under this provision.

Employees hired after December 31, 2010 must be enrolled in the Indiana State Police Health Care, Vision and Dental Plan within the first 30 days of employment and maintain continuous coverage from that date to date of separation of employment with the Department. Enrollment of an active full-time employee as a Dependent on a Spouse's plan who is an active Eligible Person under this Plan constitutes Creditable Coverage under this provision.

Employees hired on or after July 1, 2016, who are eligible and elect retiree coverage at the time of their separation of employment, will be able to carry retiree coverage for themselves and any eligible dependent(s) until the date the retiree reaches age 65 (Medicare eligible). When the retiree reaches age 65, coverage will cease for the retiree and any covered dependents.

A retiree must elect coverage on the first day he or she becomes eligible, or within 30 days of the eligibility date. Late entrants (after the 30 day period) will be denied coverage. Reentry into the plan after a lapse or termination in coverage will not be permitted.

Premium contributions for retirees covered under the Indiana State Police Pension Fund are paid directly to the Administrator by monthly coupon billing or by deduction from the pension check. All retirees covered by PERF must be coupon billed.

The Retiree Basic Plan includes only Medical and Prescription Drug coverage. The Retiree Optional Plan includes Medical, Prescription Drug, Vision and Dental coverage.

Retirees upgrading from the Basic Plan to the Optional Plan must maintain the upgraded coverage for a period of not less than three years before reducing coverage.

Dependents A Dependent becomes eligible for coverage on the effective date of the Eligible Person's coverage.

"Dependent" – The following persons, provided coverage under the plan is in effect:

- The Eligible Person's spouse.
- Any of the following who qualify as the Eligible Person's Dependent(s), until they reach the limiting age:
 1. Children;
 2. Stepchildren;
 3. Adopted children of the Eligible Person or spouse, from the earlier of: (a) the date of placement for the purpose of adoption; (b) the date of entry of a court order granting the adoptive parent custody of the child for adoption; or
 4. Children for whom the Eligible Person or spouse has legal guardianship when both parents of the child are deceased and one of the parents of the child is a member of the Enrollee's immediate family provided the child resides with the Eligible Person or spouse except in those cases when the child is no longer a same household resident while a full time student at an accredited educational institution.
- 5. Those Dependents enrolled through guardianship prior to July 1, 2000 will remain covered Dependents until the earlier of:
 - a. The Dependent reaches the Dependent limiting age: or
 - b. The Enrollee is no longer the legal guardian of the Dependent: or
 - c. The Enrollee terminates coverage of the Dependent for any reason. In this occurrence, any reinstatement of coverage for the Dependent will be subject to the requirements of the insurance plan for the department then in effect.
- In the event a child who is a "Dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the Enrollee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the Dependent Limiting Age is reached. Coverage for the "Dependent" will continue until the Enrollee discontinues his coverage or the disability no longer exists. The department may require, at reasonable intervals, but no more often than once a year, satisfactory evidence of the disability is continuing.

"Dependent Limiting Age" is the end of the month in which the child attains age 26.

Family Security

If an employee or retiree is covered under this program at the time of his or her death, his or her Dependents, including spouse, who are also covered will be eligible to remain covered under this Plan under the Family Security Program, without payment of premium for a period of three (3) months ,or until the occurrence of one of the following events, whichever is earliest:

- The date of remarriage of the surviving spouse, if any; or
- The date a Dependent ceases to meet this Plan's definition of a Dependent.

After the Family Security Program has terminated, the remaining covered Dependents may continue their coverage at the appropriate Dependent premium rate based on the retiree rate structure. Election to continue coverage must be made within 30 days of the notification of the end of the Family Security Program. Coverage elected will become effective on the first day of the month, three months following the Enrollee's death. Late entrants (after the 30-day period) will be denied coverage. Reentry into the plan after a lapse or termination in coverage will not be permitted.

Coverage for a surviving spouse will cease on the earlier of:

- The date or remarriage of the surviving spouse; or
- The date the surviving spouse dies.

Any coverage which is continued for dependent children because of the death of a covered employee or retiree will not cease because of the death of the surviving spouse within the six (6) month period following the date of the employee's or retiree's death.

The dependent benefits payable after the death of the employee or retiree will be those in effect for the dependents on the day prior to the death of the employee or retiree.

Line of Duty

Dependents, including spouses, of employees killed in the Line of Duty shall be offered health insurance coverage in accordance with IC 5-10-14. This coverage will be paid for by the Department. Dependents' coverage is subject to the Eligibility requirements of the Plan.

A surviving spouse may add additional dependents to the Plan that are acquired after the line of duty death. These Dependents are subject to the eligibility requirements of the Plan, and the premium will be based on the retiree rate structure, as follows:

One Dependent – Dependent Only rate.

Two Dependents – Retiree plus One Dependent rate.

Three or more Dependents – Retiree plus Multiple Dependents rate.

Enrollment

Participation in the plan(s) is voluntary, and employees may enroll as follows:

- New employees are given thirty-one (31) days from their date of hire to enroll in any of the programs offered by the Indiana State Police. Coverage becomes effective on the date they elect coverage by signing an approved payroll deduction form. Coverage for Dependents takes effect when the employee becomes covered.

- Dependents born or acquired after the date of enrollment must be added by completion of the appropriate forms within thirty-one (31) days of the marriage, birth, etc.
- Enrollment or changes not in accordance with above paragraphs may be made as follows:
 1. During designated open enrollment periods;
 2. Based upon the evidence of insurability policy under the TPA;
 3. Based on the qualifying events interim in the IRS Code Section 125.

Newborn Infant Coverage

The benefits payable for eligible Dependent children shall be paid for a sick or injured newborn infant of an Eligible Person for the first 31 days of his or her life. The coverage for newly adopted children will be the same as for other Eligible 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:

1. 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;
2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or
3. Continues unless required action as described below is taken.

Single Policy

To be covered beyond the first 31 days on a single policy, the newborn must be added to the Enrollee's plan membership. **The Enrollee will need to contact the Human Resources Division to obtain the appropriate enrollment forms.** The Enrollee will be liable for the higher premium for the entire pay period in which the child was added.

Family Policy

The Administrator will automatically add a newborn child to an existing family membership. The Administrator will send a notice to the Enrollee that an enrollment form must be completed with the child's name. **The Enrollee will need to contact the Human Resources Division to obtain the enrollment form.**

Note: This procedure does not apply in cases of:

- Adoption

- Marriage
- Divorce
- Guardianship

In these cases, you must contact the Human Resources Division to obtain the appropriate enrollment forms.

Qualified Medical Child Support Order/Court Ordered Health Coverage

If you are required by a qualified medical child support order or court order, as defined applicable state or federal law, to enroll your child under this Plan, the State will permit your child to enroll at any time without regard to any open enrollment limits and shall provide the benefits of this Plan in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Plan will be paid, at the Administrator's discretion, on behalf of the State, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The Plan will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Administrator directly.

Contributions

Persons who have elected coverage under the medical, vision and dental plans must authorize payroll deductions to pay their portion of the cost.

Applications

To obtain coverage with the Indiana State Police Health Care Benefit Plan, an Eligible Person must complete and submit an application to the Indiana State Police Human Resources Division. Acceptance of the application is shown by delivery of an identification card showing the Eligible Person's name and identification number.

5 TERMINATION AND CONTINUATION

Termination

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Employer's specific requirements:

- If you terminate your coverage, termination for Enrollees and Dependents will generally be effective on the earliest of:
 - The date the Administrative Service Agreement or Plan is terminated; or
 - The date the payroll deduction authorization is withdrawn; or
 - The date the premiums are due and payable and unpaid; or
 - Termination of employment (except when retiree coverage is elected); or
 - The date a Dependent ceases to be eligible as defined.

- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in this Benefit Booklet, your coverage will terminate on the last day of the billing period. If you cease to be eligible due to termination of employment, your coverage will terminate on the last day of the billing period. You must notify your Employer immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying the Plan for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Fees paid for such services.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowable Amount for services received through such misuse.

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 31 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).

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 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.)

6 DENTAL UTILIZATION REVIEW

Dental utilization review is a process designed to promote the delivery of cost-effective dental care by encouraging the use of clinically recognized and proven procedures. Dental utilization review is included in your dental benefits to encourage you to utilize your dental benefits in a cost-effective and clinically recognized manner. Your right to benefits for Covered Services provided under this Plan is subject to certain policies, guidelines and limitations, including, but not limited to, the Administrator's coverage guidelines, dental policy and utilization review features.

Dental utilization review is accomplished through pre-treatment review and retrospective review. The Administrator's dental coverage guidelines for pre-treatment review and retrospective review are intended to reflect the standards of care for dental practice and

state-specific regulations. The purpose of dental coverage guidelines is to assist in the interpretation of Medical Necessity. In order to be Covered Services under this Plan, services must meet the Medically Necessary requirements.

Pre-Treatment Review

You may have a pre-treatment review done before you receive benefits. Pre-treatment review is not a prior authorization for services but is a system that allows you and your Dentist to know, in advance, what the estimated benefits payable would be under this Plan for a proposed course of treatment. The actual benefits you receive under the plan will be determined once a claim for services has been received and may vary from the estimated benefits based upon the actual services received as well as the benefit coverage in effect

on the date(s) of services.

Under pre-treatment review, your Dentist prepares a request for a pre-treatment benefit estimation form, and submits this form to the Administrator before any treatment begins. The pre-treatment benefit estimation form should: (a) list the recommended dental services; and (b) show the charge for each dental service. The Administrator will review this request and send a copy of its estimated benefits to you and your Dentist. The Administrator may request supporting pre-operative x-rays or other diagnostic records in connection with the pre-treatment review. A pre-treatment review is recommended if the proposed course of treatment is expected to involve charges of **\$350 or more**.

If the course of treatment is not reviewed before treatment is received, it will be reviewed when the claim is submitted to the Administrator for payment.

Retrospective Review

Retrospective review means a Medical Necessity review that is conducted after dental care services

have been provided. A claim review includes, but is not limited to, an evaluation of reimbursement levels, accuracy of documentation, accuracy of coding and adjudication of payment.

The Administrator provides a toll-free telephone number available during normal business hours to assist you or your Dentist in obtaining information with respect to the Administrator's utilization review process. This same number may be utilized after business hours to leave a message which will be responded to within two business days in non-emergency situations.

If a Member disagrees with a utilization review decision and wishes to file a Grievance, or appeal a decision previously made you will find details on how to do this in the Grievance and Appeals section of this Benefit Booklet. You may also contact the Administrator's customer service number on your ID card.

The utilization review process is governed by laws and regulations, and may be modified from time to time by the Plan as those laws and regulations may require.

7 COVERED SERVICES - DENTAL

This section describes the Covered Services available under your dental care benefits when provided and billed by eligible Providers. All Covered Services are subject to the exclusions listed in the Exclusions section.

Benefits are limited to Covered Services stated in this Benefit Booklet for dental disease, prevention, diagnosis and treatment. Coverage is subject to all the terms and limitations stated in this Benefit Booklet, including special treatment schedules and benefit maximums.

Covered Dental Services

Class I - Preventive and Diagnostic Covered Services

1. Oral examinations, not more than twice a calendar year.
2. Bitewing x-rays, X-rays.
3. Full mouth x-rays, once in a 36 consecutive month period.
4. Oral prophylaxis (cleaning and scaling of teeth), not more than twice in a calendar year.
5. Topical fluoride application, not more than one treatment in a calendar year.
6. Space maintainers.

7. Extractions (except extractions for orthodontics or impacted or partially impacted teeth).

Class II - Restorative Covered Services

1. Fillings, including silver amalgam, silicate and acrylic restorations.
2. Administration of general anesthetics when medically necessary and administered in connection with oral surgery.
3. Periodontal treatment (diseases of gums).
4. Endodontic treatment (pulp infection and root canal therapy).
5. Injections of antibiotic drugs.
6. Sealants for dependent children under 19 years of age on posterior teeth.
7. Apicoectomy (considered a separate service if performed with root canal therapy)
8. Gingivectomy or gingivoplasty, per quadrant.
9. Osseous surgery, per quadrant. If more than one surgical service is performed per quadrant, only the most inclusive surgical service performed will be a Covered Service under this benefit. Flap entry and closure is considered part of the dental service of osseous surgery and osseous graft.
10. Repairs and adjustments to full or partial dentures, only if performed after six (6) months from initial installation.
11. Replacement of broken tooth of full or partial denture, only if not in conjunction with other repairs.
12. Extraction of impacted or partially impacted teeth.

Class III - Prosthodontics Covered Services

1. Crowns (porcelain and/or gold).
2. Complete dentures.

3. Partial dentures.
4. Bridge pontics (gold, porcelain, or plastic).
5. Abutment crowns (gold, porcelain, or plastic).
6. Implants.

Class IV - Orthodontic Covered Services

1. Orthodontic diagnostic procedures (including cephalometric X-rays).
2. Surgical therapy (surgical repositioning of the jaw, facial bones, and/or teeth to correct malocclusion).
3. Appliance therapy (braces) including related oral exams, surgery and extractions.

Implants

Benefits for implants include:

- Surgical placement of implants
- Implant supported Prosthetics
- Implant maintenance
- Repair of an implant
- Removal of an implant

Limitations

Covered services for surgery involving the teeth or peridontium are limited to the following:

- Excision of epulis.
- Excision of an unerupted impacted tooth, including removal of alveolar bone and sectioning tooth.
- Removal of a residual root (when performed by a dentist other than the one who extracted the tooth).
- Intraoral drainage of an acute alveolar abscess with cellulitis.

- Alveolectomy.
- Gingivectomy for gingivitis or periodontitis.

Exclusions

The following are not covered under dental:

- Services and supplies for lost or stolen dentures or appliances.
- Hospital charges, even if the admission is for dental work.
- Replacement of a bridge or denture within five (5) years following the date of its original installation unless:
 1. Replacement is made necessary by the placement of an original opposing full denture or the extraction of natural teeth; or
 2. The bridge or denture, while in the oral cavity, has been damaged beyond repair as a result of an injury received while you are covered under this Plan.
- Replacement of a bridge or denture, at any time, when the bridge or denture meets or can be made to meet commonly held dental standards of functional acceptability.
- Appliances or restorations, except full dentures when the primary purpose is to alter vertical dimension, stabilize periodontally involved teeth, or restore occlusion.
- Veneers or similar properties of crowns and pontics placed on, or replacing teeth, except the ten upper and lower anterior teeth.
- Services and supplies excluded in the exclusions section.
- Sealants to posterior teeth
- Sealants over age 19
- Lost or stolen dentures

8 EXCLUSIONS

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

The Plan does not provide benefits for services or supplies:

1. Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet.
2. Procedures not yet recognized by the American Dental Association as indicated with a specific procedure code designation.
3. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. 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;
4. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation;
5. For illness or injury that occurs as a result of any act of war, declared or undeclared;
6. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident;
7. For court ordered care, unless Medically Necessary and authorized by the Administrator, on behalf of the Employer.
8. For which you have no legal obligation to pay in the absence of this or like coverage;
9. 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;
10. Prescribed, ordered, or referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, or self.
11. For completion of claim forms or charges for medical records or reports unless otherwise required by law;
12. For missed or canceled appointments;
13. For mileage costs or other travel expenses, except as authorized by the Plan;
14. Charges in excess of the Maximum Allowable Amount;
15. Incurred prior to your Effective Date;
16. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet;
17. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein;

9 CLAIMS PAYMENT

How to Obtain Benefits

For services received from a Provider, you are responsible for making sure a claim is filed in

order to receive benefits. Many Providers will submit your claim for you. If you submit the claim use a claim form.

Maximum Allowed Amount

General

This section describes how the Plan determines the amount of reimbursement for Dental Services. Reimbursement for dental services rendered by participating and non-participating Dentists is based on your Plan's Maximum Allowed Amount for the type of service performed.

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

- that meets the Plan's definition of Dental 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 Dental Services from a non-participating Dentist, you may be responsible for paying any difference between the Maximum Allowed Amount and the Dentist's actual charges. This amount can be significant.

When you receive Dental Services from a Dentist, the Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Dental Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the dental procedure. Applying these rules may affect the Plan's determination of the Maximum Allowed Amount. The Administrator's application of these rules does not mean that the Dental Services you received were not Medically Necessary. It means the Administrator determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example,

your Dentist may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination 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 dental provider or other dental providers, the Plan may reduce the Maximum Allowed Amounts for those additional secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent a duplicate payment for a dental procedure that may have already been considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the provider is a participating Dentist or a non-participating Dentist.

Participating Dentist

A participating Dentist is a Dentist who is in the contracted network for this specific plan or who has a participation contract with the Administrator. For Dental Services performed by a participating Dentist, the Maximum Allowed Amount for your plan is the rate the Dentist has agreed with the Administrator to accept as reimbursement for the Dental Services. Because participating Dentists have agreed to accept the Maximum Allowed Amount as payment in full for those Dental 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 copay or coinsurance. Please call Customer Service for help in finding a participating Dentist or visit www.anthem.com.

Non-Participating Dentist

Dentists who have not signed any contract with the Administrator and are not in any of the Administrator's networks are non-participating Dentists.

For Dental Services You receive from a non-participating Dentist, the Maximum Allowed Amount for this plan will be one of the following as determined by the Plan:

1. An amount based on the Administrator's Non-Participating 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: record fee data, reimbursement amounts accepted by like/similar providers contracted with the Administrator, reimbursement amounts accepted by like/similar providers for the same services or supplies, or other industry cost, reimbursement and utilization data; or
2. An amount based on information provided by a third party vendor which may reflect comparable Dentists' fees and costs to deliver care; or
3. An amount negotiated by the Administrator or a third party vendor which has been agreed to by the participating Dentist; or
4. An amount equal to the total charges billed by the Dentist, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Dentists who are not contracted for this product but contracted for other products with the Administrator are also considered non-participating. For your Plan, the Maximum Allowed Amount for services from these Dentists will be one of the four methods shown above unless the contract between the Administrator and that Dentist specifies a different amount.

Unlike participating Dentists, non-participating Dentists may send You a bill

and collect for the amount of the Dentist'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 Dentist charges. This amount can be significant. Choosing a participating Dentist will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a participating Dentist or visit the Administrator's website at www.anthem.com.

Customer Service is also available to assist you in determining your Plan's Maximum Allowed Amount for a particular service from a non-participating Dentist. In order for the Administrator to assist you, you will need to obtain from your Dentist the specific procedure code(s) for the services the Dentist will render. You will also need to know the Dentist'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 Dentist.

Member Cost Share

For certain Dental 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 participating or non-participating Dentist. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using non-participating Dentists. Please see the Schedule of Benefits 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 Dentist you use.

The Plan will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your Dentist for non-covered services, regardless of whether such

services are performed by a participating or non-participating Dentist. Both services specifically excluded by the terms of your plan and those received after benefits have been exhausted are non-covered services. Benefits may be exhausted by exceeding, for example, your annual or lifetime maximum, benefit maximums or day/visit limits.

How Benefits Are Paid

The Plan shares the cost of your dental expenses with you up to the amount of the Maximum Allowable Amount. For services subject to a Deductible, you pay a portion of the bill before this Plan begins to pay its share of the balance.

You are responsible for the difference between the actual charge billed and the Maximum Allowable Amount plus any Deductible, non-covered charges, and amounts over the Annual or Lifetime Maximums. The amount you pay may differ by the type of service you receive or by Provider. Refer to the Schedule of Benefits to see what amount the Plan may pay for each service. Claims for Covered Services need not be sent to the Administrator, on behalf of the Employer in the same order that expenses were incurred.

The Plan will deny that portion of any charge which exceeds the Maximum Allowable Amount.

Payment of Benefits

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

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

Assignment

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

Notice of Claim

The Plan is not liable, unless the Administrator, on behalf of the Employer, receives written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given.

The notice must be given to the Administrator, on behalf of the Employer, within 90 days of receiving the Covered Services, and must have the data needed to determine benefits. Failure to give the Administrator, on behalf of the Employer, notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice can be submitted later than one year after the usual 90 day filing period ends. 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, on behalf of the Employer, within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

Note: You have the right to obtain an itemized copy of your billed charges from the Hospital or facility which provided services.

Claim Forms

Many Providers will file for you. If the forms are not available, either send a written request for claim forms to the Administrator or contact the Administrator's customer service and ask for claim forms to be sent to you. The form will be sent to

you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to the Administrator without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

Proof of Claim

Written proof of claim satisfactory to the Administrator must be submitted to the Administrator within 90 days after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to do send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to the Administrator no later than one year following the 90 day period specified, unless you were legally incapacitated.

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, on behalf of the Employer, will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information,

for your information. In those cases, the Administrator cannot complete the processing of the claim until the additional information requested has been received. The Plan generally will make its request for additional information within 30 days of the initial receipt of the claim and will complete the processing of the claim within 15 days after the 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.

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, Worker's Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

Explanation of Benefits

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

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any)

10 GENERAL PROVISIONS

Entire Agreement

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

Form or Content of Benefit Booklet

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

Disagreement with Recommended Treatment

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

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

Circumstances Beyond the Control of the Plan

The Administrator, on behalf of the Employer, shall make a good-faith effort to arrange for an alternative method of administering benefits. In the event of circumstances not within the control of the Administrator or Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Administrator, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided by the Plan is delayed or rendered impractical. In such event, the Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Administrator and Network Providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits

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

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

In the rest of the Benefit Booklet, Plan has the meaning listed in the **Definitions** section.

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

Because the Allowable expense may be the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider may be allowed to bill you for any remaining Coinsurance, Deductible, and/or Copayment under the higher allowable amount. This higher allowable amount may be more than the Plan's allowed 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 Medicare, 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 dental 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 dental 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 dental 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 or dental care expense, including Deductibles and/or Coinsurance, 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. 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.
2. 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.
3. 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.
4. 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.

Closed panel plan is a Plan that provides dental 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 dental care expenses or dental 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 dental care expenses or dental 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 dental care expenses or dental 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 dental care expenses or dental 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 dental 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 and/or Deductible 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 dental 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 dental care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. The Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. The Administrator, on behalf of the Employer, need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Administrator any facts it needs to 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.

Physical Examination

The Administrator, on behalf of the Employer, reserves the right to cause you to be examined by an applicable Provider as often as may be reasonably required during the pendency of a claim.

Worker's Compensation

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

Other Government Programs

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

Subrogation and 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.

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

Clerical Error

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

Policies and Procedures

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

Waiver

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

Employer's Sole Discretion

The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice

from the Administrator, determines such services and supplies are in lieu of more expensive services

and supplies which would otherwise be required for the care and treatment of a Member.

11 MEMBER GRIEVANCES

Grievances

If you are dissatisfied with dental treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact the Administrator, either orally or in writing to obtain information on the Administrator's Grievance procedures or to file a Grievance with the Plan.

You have the right to designate a representative (e.g. your Dentist) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with the Administrator on your behalf and to represent you in a Grievance or an Appeal. If a representative seeks a Grievance or an Appeal on your behalf, the Administrator must obtain a signed Designation of Representation form from you before the Administrator can deal directly with your representative. The Administrator will forward a Designation of Representation form to you for completion. If the Administrator do not obtain a signed Designation of Representation form, the Administrator will continue to research your Grievance but will respond only to you unless a signed Designation of Representation form is received.

The Administrator will accept oral or written comments, documents or other information relating to the grievance from the Member or the Member's provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's appeal.

To obtain information on the Plan's Grievance procedures or to file a Grievance orally with the Administrator, please call the toll free customer service number listed on the back of your Plan Identification Card. A representative

from the Administrator who is knowledgeable about the Plan's Grievance procedures and any applicable laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call the Administrator at 1-800-627-0004 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified representative from the Administrator.

The Administrator will also accept Grievances filed in writing. If you wish to file your Grievance in writing, mail it to: Anthem Blue Cross and Blue Shield, Grievance Department, P.O. Box 659471, San Antonio, TX 78265-9471.

Upon the Administrator's receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from the Administrator), an acknowledgment will be sent to you within 5 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. The Administrator's acknowledgment may be oral for those Grievances the Administrator receives orally. All Grievances will be resolved by the Administrator within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from the Administrator).

If your Grievance cannot be resolved within 20 business days due to the Administrator's need for additional information you will be notified in

writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from the Administrator's original request. In the event of an extension, the Administrator will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, the Administrator will make a determination based on the information in the Administrator's possession.

Within 5 business days after the Grievance is resolved, the Administrator will send a letter to you notifying you of the decision reached.

Appeals

If the Administrator's decision under the Grievance process is satisfactory to you, the matter is concluded. If the Administrator's decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Administrator either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of the Administrator's receipt of your Appeal request. The Administrator's acknowledgment may be oral for those Appeals the Administrator receives orally. The Administrator will set a date and time during normal business hours for the

Administrator's Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by the Administrator. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by the Administrator of the Administrator's decision concerning your Appeal.

Grievance/Appeal Filing Time Limit

The Administrator expects that you will use good faith to file a Grievance or an Appeal on a timely basis. However, the Administrator will not review a Grievance if it is received by the Administrator after the end of the calendar year plus 12 months have passed since the incident leading to your Grievance. The Administrator will accept Appeals filed within 60 days after you are notified of the Administrator's decision concerning your Grievance.

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Administered by Anthem Insurance Companies, Inc.

Your Vision Benefit Booklet

Vision Benefit Booklet

Blue View Vision

Indiana State Police

**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.

BENEFIT BOOKLET

Welcome to Anthem Blue Cross and Blue Shield! This Benefit Booklet has been prepared by the Administrator, on behalf of the Employer, to help explain your vision care benefits. Please refer to this Benefit Booklet whenever you require vision services. It describes how to access vision care, what vision services are covered by the Plan, and what portion of the vision care costs you will be required to pay.

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 vision care benefits.

This Benefit Booklet should be read in its entirety. Since many of the provisions of this Benefit Booklet are interrelated, you should read the entire Benefit Booklet to get a full understanding of your coverage.

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

Read your Benefit Booklet Carefully. The Benefit Booklet sets forth many of the rights and obligations between you and the Plan. Payment of benefits is subject to the provisions, limitations and exclusions of your Benefit Booklet. It is therefore important that you read your Benefit Booklet.

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1 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the amount of benefits available when you receive Covered Services from a Provider. Please refer to the Covered Services section for a more complete explanation of the specific vision services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Benefit Booklet including any attachments or riders.

CHOICE OF VISION CARE PROVIDER: Nothing contained in this Benefit Booklet restricts or interferes with your right to select the Vision Care Provider of your choice, but your benefits are reduced when you use a Non-Network Provider.

DEPENDENT AGE LIMIT

To the end of the month in which the child attains age 26.

COVERED SERVICES

COPAYMENT/MAXIMUMS

Exam

Limited to one exam per Member every 12 months.*

Network

\$15 Copayment

Non-Network

Reimbursed up to \$50

Prescription Lenses (including factory scratch coating polycarbonate lenses for children under 19 years old and Photochromic lenses for children under 19 years old.)

\$15 Copayment

Basic Lenses (Pair)

- Single Vision Lenses
- Bifocal Lenses
- Trifocal Lenses
- Lenticular Lenses

Reimbursed up to \$50

Reimbursed up to \$70

Reimbursed up to \$90

Reimbursed up to \$110

Limited to one set of lenses per Member every 12 months*

Frames (Limited to one set of frames per Member every 12 months *)

\$0 Copayment Any frame up to \$120 retail

Reimbursed up to \$50

Prescription Contact Lenses

(traditional or disposable)

- **Non-Elective Contact Lenses** (Availability once every 12 months *) \$0 Copayment (non-elective contact lenses are reimbursed up to \$120) Non-Elective Contact Lenses are Reimbursed up to \$75

- **Elective Contact Lenses** (Availability once every 12 months*) \$0 Copayment Elective contact lenses are reimbursed up to \$125 Elective Contact Lenses are Reimbursed up to \$125

Note: If you chose covered Non-Elective Contact Lenses or Elective Contact Lenses, no benefits will be available for covered eyeglass lenses and frames in that period.

* from the Last Date of Service.

2 DEFINITIONS

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

Additional Savings Program – A discount program associated with Network Providers. It can be used for certain non-covered services and plan overages. The discount plan is subject to change at any time.

Administrative Services Agreement - The agreement between the Administrator and the Employer regarding the administration of certain elements of the vision care benefits of the Employer's group vision plan.

Administrator - An organization or entity that the Employer contracts with to provide administrative and claims payment services under this 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.

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

Coinsurance - A percentage of the Maximum Allowable Amount for which you are responsible to pay. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

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

- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Plan is in force;
- Within the Maximum Allowable Amount;

- Not specifically excluded or limited by the Plan;
- Specifically included as a benefit within the Benefit Booklet.

A Covered Service is incurred on the date the service, supply or treatment was provided to you.

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

Effective Date – The date that a Subscriber's coverage begins under the Plan. A Dependent's coverage also begins on the Subscriber's Effective Date.

Elective Contact Lenses - All prescription contact lenses that are cosmetic in nature or Non-Elective Contact Lenses.

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

Employer – The legal entity contracting with the Administrator for administration of group vision 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).

Fees - 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.

Last Date of Service – The period of time in which benefits are tracked. The Member must wait until the specific interval from the last date of service to receive Covered Services as listed in the Schedule of Benefits.

Lenses - Materials prescribed for the visual welfare of the patient. Materials would include single vision, bifocal, trifocal or other more complex lenses.

Maximum Allowable Amount - The maximum amount allowed for Covered Services you receive based on the fee schedule. The

Maximum Allowable Amount is subject to any Copayments, Coinsurance, limitations or Exclusions listed in this Benefit Booklet.

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

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

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

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.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by the Administrator, on behalf of the Employer, to provide Covered Services and certain administration functions for the Network associated with this Plan.

Non-Elective Contact Lenses - Contact lenses which are provided for reasons that are not cosmetic in nature. Non-Elective Contact Lenses are Covered Services when the following conditions have been identified or diagnosed:

- Extreme visual acuity or other functional problems that cannot be corrected by spectacle lenses; or
- Keratoconus-unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or

- High Ametropia-unusually high levels of near sightedness, far sightedness, or astigmatism are identified; or
- Anisometropia-when one eye requires a much different prescription than the other eye.

Non-Network Provider - A Provider who has not entered into a contractual agreement with the Administrator, on behalf of the Employer, for the Network associated with this Plan.

Plan – The group vision benefit plan

provided by the Employer and explained in this Benefit Booklet.

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 that are required by applicable state law to be covered when rendered by such Provider.

Subscriber - An employee or Member of the Employer who is eligible to receive benefits under the Plan.

3 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

Employees All active full-time Indiana State Police employees regularly scheduled to work not less than 37 $\frac{1}{2}$ hours per week are eligible, as are disabled employees, their spouses and their eligible "Dependents".

An eligible Dependent of an employee becomes eligible for coverage on the effective date of the employee's coverage.

If a Dependent, other than a newborn infant of an Enrollee, is confined in a hospital on the date his or her coverage would otherwise begin, his or her coverage will become effective upon final medical release from such confinement.

Retirees A retiree becomes eligible for coverage either: 1) the month he or she retires (if the retirement becomes effective on the first day of that month); or 2) the first day of the month following the date retirement becomes effective, if he or she:

- Has completed 25 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or
- Is age 65, has completed 10 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or
- Is age 60, has completed 15 years of Creditable Service and is immediately eligible for an unreduced pension benefit; or

- Is age 55, age plus years of Creditable Service equals 85 or more, and is immediately eligible for an unreduced pension benefit.

Additional eligibility requirements for retiree coverage:

Employees hired prior to December 31, 2010 must be enrolled in the Indiana State Police Health Care, Vision and Dental Plan by no later than January 1, 2011 and maintain continuous coverage from that date to date of separation of employment with the Department. Enrollment of an active full-time employee as a Dependent on a Spouse's plan who is an active Eligible Person under this Plan constitutes Creditable Coverage under this provision.

Employees hired after December 31, 2010 must be enrolled in the Indiana State Police Health Care, Vision and Dental Plan within the first 30 days of employment and maintain continuous coverage from that date to date of separation of employment with the Department. Enrollment of an active full-time employee as a Dependent on a Spouse's plan who is an active Eligible Person under this Plan constitutes Creditable Coverage under this provision.

Employees hired on or after July 1, 2016, who are eligible and elect retiree coverage at the time of their separation of employment, will be able to carry retiree coverage for themselves and any eligible dependent(s) until the date the retiree reaches age 65 (Medicare eligible). When the retiree reaches age 65, coverage will cease for the retiree and any covered dependents.

A retiree must elect coverage on the first day he or she becomes eligible, or within 30 days of the eligibility date. Late entrants (after the 30 day period) will be denied coverage. Reentry into the plan after a lapse or termination in coverage will not be permitted.

Premium contributions for retirees covered under the Indiana State Police Pension Fund are paid directly to the Administrator by monthly coupon billing or by deduction from the pension check. All retirees covered by PERF must be coupon billed.

The Retiree Basic Plan includes only Medical and Prescription Drug coverage. The Retiree Optional Plan includes Medical, Prescription Drug, Vision and Dental coverage.

Retirees upgrading from the Basic Plan to the Optional Plan must maintain the upgraded coverage for a period of not less than three years before reducing coverage.

Dependents A Dependent becomes eligible for coverage on the effective date of the Eligible Person's coverage.

"Dependent" – The following persons, provided coverage under the plan is in effect:

- The Eligible Person's spouse.
- Any of the following who qualify as the Eligible Person's Dependent(s), until they reach the limiting age:
 1. Children;
 2. Stepchildren;
 3. Adopted children of the Eligible Person or spouse, from the earlier of: (a) the date of placement for the purpose of adoption; (b) the date of entry of a court order granting the adoptive parent custody of the child for adoption; or

4. Children for whom the Eligible Person or spouse has legal guardianship when both parents of the child are deceased and one of the parents of the child is a member of the Enrollee's immediate family provided the child resides with the Eligible Person or spouse except in those cases when the child is no longer a same household resident while a full time student at an accredited educational institution.
5. Those Dependents enrolled through guardianship prior to July 1, 2000 will remain covered Dependents until the earlier of:
 - a. The Dependent reaches the Dependent limiting age: or
 - b. The Enrollee is no longer the legal guardian of the Dependent: or
 - c. The Enrollee terminates coverage of the Dependent for any reason. In this occurrence, any reinstatement of coverage for the Dependent will be subject to the requirements of the insurance plan for the department then in effect.
- In the event a child who is a "Dependent" as defined herein, is incapable of self-sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the Enrollee for support and maintenance prior to age 19, such child's coverage will continue if satisfactory evidence of such disability and dependency is received within 120 days after the Dependent Limiting Age is reached. Coverage for the "Dependent" will continue until the Enrollee discontinues his coverage or the disability no longer exists. The department may require, at reasonable intervals, but no more often than once a year, satisfactory evidence of the disability is continuing.

"Dependent Limiting Age" is the end of the month in which the child attains age 26.

Family Security

If an employee or retiree is covered under this program at the time of his or her death, his or her Dependents, including spouse, who are also covered will be eligible to remain covered under this Plan under the Family Security Program, without payment of premium for a period of three (3) months, or until the occurrence of one of the following events, whichever is earliest:

- The date of remarriage of the surviving spouse, if any; or
- The date a Dependent ceases to meet this Plan's definition of a Dependent.

After the Family Security Program has terminated, the remaining covered Dependents may continue their coverage at the appropriate Dependent premium rate based on the retiree rate structure. Election to continue coverage must be made within 30 days of the notification of the end of the Family Security Program. Coverage elected will become effective on the first day of the month, three months following the Enrollee's death. Late entrants (after the 30-day period) will be denied coverage. Reentry into the plan after a lapse or termination in coverage will not be permitted.

Coverage for a surviving spouse will cease on the earlier of:

- The date or remarriage of the surviving spouse; or
- The date the surviving spouse dies.

Any coverage which is continued for dependent children because of the death of a covered employee or retiree will not cease because of the death of the surviving spouse within the six (6) month period following the date of the employee's or retiree's death.

The dependent benefits payable after the death of the employee or retiree will be those in effect for the dependents on the day prior to the death of the employee or retiree.

Line of Duty

Dependents, including spouses, of employees killed in the Line of Duty shall be offered health insurance coverage in accordance with IC 5-10-14. This coverage will be paid for by the Department. Dependents' coverage is subject to the Eligibility requirements of the Plan.

A surviving spouse may add additional dependents to the Plan that are acquired after the line of duty death. These Dependents are subject to the eligibility requirements of the Plan, and the premium will be based on the retiree rate structure, as follows:

One Dependent – Dependent Only rate.

Two Dependents – Retiree plus One Dependent rate.

Three or more Dependents – Retiree plus Multiple Dependents rate.

Enrollment

Participation in the plan(s) is voluntary, and employees may enroll as follows:

- New employees are given thirty-one (31) days from their date of hire to enroll in any of the programs offered by the Indiana State Police. Coverage becomes effective on the date they elect coverage by signing an approved payroll deduction form. Coverage for Dependents takes effect when the employee becomes covered.
- Dependents born or acquired after the date of enrollment must be added by completion of the appropriate forms within thirty-one (31) days of the marriage, birth, etc.
- Enrollment or changes not in accordance with above paragraphs may be made as follows:
 1. During designated open enrollment periods;
 2. Based upon the evidence of insurability policy under the TPA;
 3. Based on the qualifying events interim in the IRS Code Section 125.

Newborn Infant Coverage

The benefits payable for eligible Dependent children shall be paid for a sick or injured newborn infant of an Eligible Person for the first 31 days of his or her life. The coverage for newly adopted children will be the same as for other Eligible 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:

1. 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;
2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or
3. Continues unless required action as described below is taken.

Single Policy

To be covered beyond the first 31 days on a single policy, the newborn must be added to the Enrollee's plan membership. **The Enrollee will need to contact the Human Resources Division to obtain the appropriate enrollment forms.** The Enrollee will be liable for the higher premium for the entire pay period in which the child was added.

Family Policy

The Administrator will automatically add a newborn child to an existing family membership. The Administrator will send a notice to the Enrollee that an enrollment form must be completed with the child's name. **The Enrollee will need to contact the Human Resources Division to obtain the enrollment form.**

Note: This procedure does not apply in cases of:

- Adoption
- Marriage
- Divorce
- Guardianship

In these cases, you must contact the Human Resources Division to obtain the appropriate enrollment forms.

Qualified Medical Child Support Order/Court Ordered Health Coverage

If you are required by a qualified medical child support order or court order, as defined applicable state or federal law, to enroll your child under this Plan, the State will permit your child to enroll at any time without regard to any open enrollment limits and shall provide the benefits of this Plan in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under this Plan will be paid, at the Administrator's discretion, on behalf of the State, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The Plan will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Administrator directly.

Contributions

Persons who have elected coverage under the medical, vision and dental plans must authorize payroll deductions to pay their portion of the cost.

Applications

To obtain coverage with the Indiana State Police Health Care Benefit Plan, an Eligible Person must complete and submit an application to the Indiana State Police Human Resources Division. Acceptance of the application is shown by delivery of an identification card showing the Eligible Person's name and identification number.

4 TERMINATION AND CONTINUATION

Termination

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Employer's specific requirements:

- If you terminate your coverage, termination for Enrollees and Dependents will generally be effective on the earliest of:
 - The date the Administrative Service Agreement or Plan is terminated; or
 - The date the payroll deduction authorization is withdrawn; or
 - The date the premiums are due and payable and unpaid; or
 - Termination of employment (except when retiree coverage is elected); or
 - The date a Dependent ceases to be eligible as defined.
- Subject to any applicable continuation or conversion requirements, if you cease to meet eligibility requirements as outlined in this Benefit Booklet, your coverage will terminate on the last day of the billing period. If you cease to be eligible due to termination of employment, your coverage will terminate on the last day of the billing period. You must notify your Employer immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying the Plan for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Fees paid for such services.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must

reimburse the Plan for the Maximum Allowable Amount for services received through such misuse.

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 31 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).

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 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.)

5 HOW TO OBTAIN COVERED SERVICES

Network Services and Benefits

If a Network Provider renders your care, benefits will be provided at the Network level. Refer to the Schedule of Benefits. No benefits will be provided for care that is not a Covered Service even if performed by a Network Provider.

The Administrator may inform you that a service you received is not a Covered Service under the Plan. You may appeal this decision. See the Complaint and Appeals Procedures section of this Benefit Booklet.

Network Providers are Professional Providers and other facility Providers who contract with the Administrator, on behalf of the Employer, to perform services for you. You will not be required to file any claims for services you obtain directly from Network Providers.

Non-Network Services and Benefits

Services that are not obtained from a Network Provider will be considered a Non-Network Service. In addition, certain services may not be covered unless obtained from a Network Provider, and/or may result in higher cost-share amounts. See your Schedule of Benefits. You will be required to file claims for services that you obtain directly from a Non-Network Provider.

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 Provider or in any Provider's facilities.

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

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Benefit Booklet does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of vision care, services or supplies, does or does not do.

6 COVERED SERVICES

This section describes the Covered Services available under your vision care benefits when

provided and billed by eligible Providers. All Covered Services are subject to the exclusions

listed in the Exclusions section and all other conditions and limitations of the Benefit Booklet. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Schedule of Benefits.

The following are Covered Services:

- Routine Eye exam
- Standard Eyeglass Lenses
- Frames
- Contact Lenses in lieu of Eyeglass Lenses

Services and materials obtained through a Non-Network Provider are subject to the same Exclusions and limitations as services through a Network Provider.

If you choose a frame that is valued at more than the Maximum Allowable Amount you are responsible for the difference in cost.

If a Member elects either covered Non-Elective or Elective Contact Lenses within one 12-month period, no benefits will be paid for covered lenses and frames until the next 12-month period.

Routine Eye Exam

The Plan covers up to a comprehensive eye examination including dilation as needed minus any applicable Copayment. The eye examination may include the following:

- Case history
- Recording corrected and uncorrected visual acuity
- Internal exam
- External exam
- Pupillary reflexes
- Binocular vision

- Objective refraction
- Subjective refraction
- Glaucoma test
- Slit lamp exam (Biomicroscopy)
- Dilation
- Color vision
- Depth perception
- Diagnosis and treatment plan.

Eyeglass Lenses

Eyeglass Lenses are available in standard or basic plastic (CR39) Lenses including single vision, bifocal, and trifocal with factory coating with polycarbonate lenses for children under 19 and photochromic lenses for children under 19. If you choose progressive Lenses that are no line bifocals, there will be an additional cost. All eyeglass Lenses are subject to the applicable Copayment listed in the Schedule of Benefits. There may also be an additional cost for any add-ons to the lenses such as anti-reflective coating or ultra-violet coating. These and any other lens add-ons may be discounted according to the Plan's Additional Savings Program.

Frames

The frame allowance is based upon the retail cost. The Member may apply the plan allowance toward the Network Provider's selection of frames. The Schedule of Benefits lists the frames allowance available under your plan. If you choose a set of frames that are valued at more than the Maximum Allowable Amount, you are responsible for the balance based upon the Additional Savings Program.

Elective Contact Lenses

The contact lens allowance must be completely used at the time of initial service. No amount of the allowance may be carried forward to use during another service date. The Schedule of Benefits list the contact lens allowance available under this Plan.

Non-Elective Contact Lenses

This benefit is available for a limited number of diagnoses and is in lieu of the standard contact lens or Lenses and frames benefit.

Eligibility

Conditions that provide eligibility for consideration of this Non-Elective Contact Lens benefit include:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle Lenses.
- High Ametropia exceeding -12 D or +9 D in spherical equivalent.
- Anisometropia of 3 D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle Lenses.

Fitting Fees

The Member is responsible for 100% of the fitting fee at the time of service. However, the Plan's Maximum Allowable Amount reimbursement

paid to the prescribing Provider for Non-Elective Contact Lenses may include a portion, or all, of the fitting fee. Any remaining amount will be applied to the Provider's fitting fee.

SPECIAL NOTE: The Plan will not reimburse for Non-Elective Contact Lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

Cosmetic Options

Benefits are available for the services below in accordance with the Additional Savings Program. The Member will be responsible for the following items at a discounted rate when provided by a Network Provider.

- Blended Lenses
- Contact Lenses (except as noted herein)
- Oversize Lenses
- Progressive multifocal Lenses
- Photochromatic Lenses, or tinted Lenses
- Coated Lenses
- Frames that exceed the Maximum Allowable Amount
- Cosmetic Spectacle Lenses
- Ultra-violet coating
- Scratch resistant coating
- Polycarbonate Lenses
- Anti-reflective coating
- Optional cosmetic items

7 EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. This information is

provided as an aid to identify certain common items that may be misconstrued as Covered Services, but is in no way a limitation upon, or a

complete listing of, such items considered not to be Covered Services.

The Plan does not provide vision benefits for services, supplies or charges:

1. Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet.
2. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. 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.
3. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
4. For illness or injury that occurs as a result of any act of war, declared or undeclared.
5. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. Received from an optical or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
8. Prescribed, ordered, referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
9. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
10. For missed or canceled appointments.
11. In excess of Maximum Allowable Amount.
12. Incurred prior to your Effective Date.
13. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
14. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
15. For sunglasses and accompanying frames.
16. For safety glasses and accompanying frames.
17. For inpatient or outpatient hospital vision care.
18. For Orthoptics or vision training and any associated supplemental testing.
19. For non-prescription lenses.
20. For two pairs of glasses in lieu of bifocals.
21. For Plano lenses (lenses that have no refractive power).
22. For medical or surgical treatment of the eyes.
23. Lost or broken lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
24. For services or supplies not specifically listed in the Benefit Booklet.
25. Certain brands on which the manufacturer imposes a no discount policy.
26. For services or supplies combined with any other offer, coupon or in-store advertisement.

8 CLAIMS PAYMENT

Obtaining Services/Claim Payment

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. If you elect to obtain services from a Non-Network Provider you must pay the entire bill at the time the services are rendered. To request reimbursement for Covered Services the Administrator will need the following information:

- The name, address and phone number of the Non-Network Provider along with an itemized statement of charges
- The covered Member's name and address, group number, Social Security number or Member identification number
- The patient's name, birthdate and relationship to the Member

The Member should keep a copy of the information and send the originals to the following address:

BlueView Vision Claims Administration
PO BOX 8504
Mason, OH 45040-7111

Notice of Claim

The Plan is not liable, unless the Administrator receives written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given.

The notice must be given to the Administrator, on behalf of the Employer, within 90 days of receiving the Covered Services, and must have the data the Administrator needs to determine benefits. 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

can be submitted later than one year after the usual 90 day filing period ends. 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.

Claim Forms

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

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

Proof of Claim

Written proof of claim satisfactory to the Administrator must be submitted to the Administrator within 90 days after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to do send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to the Administrator no later than one year following the 90 day period specified, unless you were legally incapacitated.

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, Worker's Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

Explanation of Benefits

After you receive vision care, you will often 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);

9 GENERAL PROVISIONS

Entire Agreement

This Benefit Booklet, the Administrative Services Agreement, the Employer's application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire agreement 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.

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.

Coordination of Benefits

This Plan is considered primary in all circumstances.

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.

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.

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

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

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.

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.

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.

10 COMPLAINT AND APPEALS

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

- Your coverage and benefit levels, including Reimbursement amounts;
- Specific claims or services you have received;

You will be notified, in writing, if a claim or other request for benefits is denied in whole or in part. If such a request is denied, the notice of denial will explain why benefits were denied and describe your rights under the Appeals Procedure. A Complaint Procedure also exists to help you understand the Plan's determinations.

The Complaint Procedure

A Complaint Procedure is available to provide reasonable, informative responses to complaints that you may have concerning the Plan. A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Plan of its procedures and contracts. The Plan invites you to share any concerns that you may have over benefit determinations or coverage cancellations. If you have a complaint or problem concerning benefits or services, please contact the Administrator. You may submit your complaint by letter or by telephone call. Or, if you wish, you may meet with your local service representative to discuss your complaint.

Members are encouraged to file complaints within 60 days of an initial, adverse action, but must file within six months after receipt of notice

of the initial, adverse action. The time required to review complaints does not extend the time in which appeals must be filed.

The Appeals Procedure

An appeal is a formal request from you for the Plan to change a previous determination. If you are notified in writing of a Coverage Denial or any other adverse decision by the Administrator, you will be advised of your right to an internal appeal.

A Coverage Denial means the Administrator's determination that a service, treatment, drug or device is specifically limited or excluded under this Plan.

The internal appeals process may be initiated by the Member, the Member's authorized representative, or a Provider acting on behalf of the Member within 60 days of receipt of the Plan written notice of a Coverage Denial, or any other adverse decision made by the Administrator, but must be filed within six months of your receipt of the initial decision. The request should include any medical information pertinent to the appeal. All portions of the medical records that are relevant to the appeal and any other comments, documents, records or other information submitted by the Member relating to the issue being appealed, regardless of whether such information was considered in making the initial decision, will be considered in the review of the appeal. Any new medical information pertinent to the appeal will also be considered. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member's appeal.

If a representative is seeking an appeal on behalf of a Member, the Administrator must obtain a signed Designation of Representation (DOR) form from the Member. The appeal process will not begin until the Administrator has received the properly completed DOR. The Administrator will forward a Designation of Representation form to the Member for completion.

The individuals responsible for reviewing your request for an internal appeal will not be the same individuals who made the initial denial or

determination. They will not be the subordinates of the initial decision-maker either and no deference will be given to the initial decision.

Within a reasonable period of time but no later than 30 days after receiving a written or an oral request for an appeal, the Administrator will send a written decision to the Member or their authorized representative.

Contact Person For Appeals

The request for an internal appeal must be submitted to the following address or telephone number or to the appeal address or telephone number provided on your written notice of an adverse decision:

Blue View Vision
 ATTN: Appeals
 555 Middle Creek Parkway
 Colorado Springs, CO 80921
 Telephone Number: 866-723-0515

The person holding the position named above will be responsible for processing your request.

The Plan encourages its Members to submit requests for appeal in writing. The request for appeal should describe the problem in detail. Attach copies of bills, medical records, or other appropriate documentation to support the appeal that may be in your possession.

You must file appeals on a timely basis. As stated above, you are encouraged to file internal appeals within 60 days of your receipt of the Plan's initial decision. Internal appeals must be filed, however, within six months of your receipt of the initial decision.

Vision Services

The Plan is not liable for the furnishing of Covered Services, but merely for the payment of them. You shall have no claim against the Plan for acts or omissions of any Provider from whom you receive Covered Services. The Plan has no responsibility for a Provider's failure or refusal to give Covered Services to you.

Limitation of Actions

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 no earlier than 60 days after the Administrator receives the claim or other request for benefits and 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 before filing a lawsuit or other legal action of any kind against the Plan.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة. (TTY/TDD: 711)

Armenian

Ղուր իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناساییتان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French

Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo

Bee ná aḥóót'í t'áá ni nizaad k'ehjí níká a'doowo!t'áá jík'e. Naaltsos bee atah nilinigií bee nécho'dólzingo nanitinigií bécsh bee hane'í bikáá' áájj' hodiilnih. Naaltsos bee atah nilinigií bee nécho'dólzingo nanitinigií bécsh bee hane'í bikáá' áájj' hodiilnih. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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:

Group Identification Number:

Subgroup Identification Number:

Mail to group.