GEORGIA MUNICIPAL ASSOCIATION

GEORGIA MUNICIPAL EMPLOYEES BENEFIT SYSTEM

POS

Point of Service

HEALTH PLAN BOOKLET

2020

INTRODUCTION

This booklet summarizes the POS option under the Health Plan for Active Employees (the "Plan") established by the Georgia Municipal Employees Benefit System (GMEBS) (the "Plan Sponsor"), and administered in part by Georgia Municipal Association (the "Program Administrator") and in part by Claims Administrators and any COBRA Administrator designated by the Program Administrator.

The Plan provides the benefits described in this booklet only for eligible Participants and only in accordance with the Plan Documents. The health care services (medical and pharmacy) are subject to the limitations, exclusions, Copayments, Deductible, and Coinsurance requirements specified in this booklet and in the Plan Documents. Any booklet or summary of benefits which you received previously will be replaced by this booklet and its corresponding Schedule of Benefits.

Anthem, Inc. **(herein called the Medical Claims Administrator or Anthem)**, an Independent Licensee of the Blue Cross and Blue Shield Association, administers the medical benefits under the **GMEBS Health Plan**. **Aetna Pharmacy Management (herein called the Pharmacy Claims Administrator or Aetna),** administers the pharmacy benefits under the Plan. Neither the Plan Sponsor nor the Program Administrator administers claims for medical or pharmacy benefits.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this booklet carefully. If you have any questions about how much coverage costs, please contact your employer. If you have any questions about the eligibility and enrollment provisions in this booklet, please contact the Program Administrator. If you have any questions about the benefits presented in this booklet, please contact the Customer Service Department of the Medical Claims Administrator or the Pharmacy Claims Administrator at one of the numbers listed below. Every effort has been made to accurately summarize the terms and conditions of the Plan in this booklet. However, the full terms and conditions of the Plan are set forth in the Plan Documents.

GENERAL TERMS AND CONDITIONS

Self-Insured Plan. This is not an insured benefit Plan. The benefits described in this booklet (or any rider or amendment attached hereto) are self-insured. Anthem, Inc. and Aetna Pharmacy Management provide claims administration services to the Plan, but neither insures the benefits described. This booklet is not a contract. The benefits and other terms of coverage described in this booklet and in set forth in the Plan Documents may be changed at any time.

Plan Benefits. The Plan provides the benefits described in this booklet only for eligible Participants and only in accordance with the Plan Documents. The health care services (medical and pharmacy) are subject to the limitations, exclusions, Copayments, Deductible, and Coinsurance requirements specified in this booklet and in the Plan Documents. Any booklet or summary of benefits which you received previously will be replaced by this booklet and its corresponding Schedule of Benefits.

No Responsibility for Treatment. The Plan does not supply you with a Hospital or Physician. In addition, the Plan, the Program Administrator, and the Claims Administrators are not responsible for any Injuries or damages you may suffer due to actions of any Hospital, Physician or other person. In order to process your claims or provide Plan administration services, the Claims Administrator or the Program Administrator may request additional information about the medical treatment you received and/or other group health insurance you may have. This information will be treated in accordance with the Notice of Privacy Practices for GMEBS Health and Dental Plans, which is posted at www.gacities.com/LHForms under Annual Notices.

Verbal Explanation not Binding. A verbal explanation of the terms of the Plan by an employee, agent, or representative of a Claims Administrator, the Program Administrator, or the Participating Employer is not legally binding. The terms of the Plan are set forth in the Plan Documents.

Update Your Address. Any correspondence mailed to Participants will be sent to the most current address for the Participant as shown in the records of the Plan, which are maintained by the Program Administrator. Participants are responsible for providing accurate and complete mailing address information upon their enrollment in the Plan, and for promptly notifying the Program Administrator of any change in their address. If a covered dependent has a different mailing address than that of the Employee, the Program Administrator must be notified of such different mailing address upon enrollment of the dependent and/or when the dependent obtains such different mailing address, as applicable.

Fraudulent Statements and Prohibition on Rescissions. Fraudulent statements on Plan application forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding coverage. The Plan is obligated to meet the requirements of Section 2712 of the Public Health Service Act, relating to the prohibition on rescissions. As part of such compliance, the Plan will not rescind your health coverage, except in the case where you (or a person seeking coverage on your behalf) has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact. In such case, the plan will provide you with 30 days advance written notice before coverage is rescinded. A rescission is a cancellation or discontinuance of coverage that has retroactive effect. The Program Administrator may still cancel or discontinue coverage effective retroactively to the extent that it is attributable to your or your employer's failure to timely pay required premiums or contributions towards the cost of coverage. Nothing in this paragraph prohibits the Program Administrator from cancelling or discontinuing coverage prospectively for any reason provided under the Plan.

Unauthorized Use of Identification Card. If you permit your Anthem Identification Card or your Aetna Identification Card to be used by someone else, or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of coverage.

Changes in Coverage, Benefits. Neither this booklet nor the Plan Documents should be construed as creating any vested rights to benefits in favor of any person. Any of the provisions or benefits of the Plan may be amended, curtailed, or terminated at any time without prior notice.

Recovery of Overpayments. No person is entitled to any benefit under the Plan except as expressly provided under the Plan. The fact that payments have been made from the Plan does not establish a person's right to benefits, or to have such benefits continue for any period of time. It also does not prevent the Plan from recovering benefits paid to the extent that the Claims Administrator (with respect to medical or pharmacy claims) or the Program Administrator (with respect to eligibility and enrollment) determines that there was no right to payment of benefits under the Plan. If a benefit is paid to a person and it is later determined that such benefit should not have been paid, then the Program Administrator or Claims Administrators may take actions to recover the over payment or remedy the situation.

Acts Beyond Reasonable Control (Force Majeure). The Plan Sponsor, Program Administrator and Claims Administrators will be relieved of their responsibilities under the Plan if their duties become impossible to perform by acts of God, war, terrorism, fire or any other cause beyond their reasonable control.

Requirement to Exhaust Internal Appeals before Filing a Lawsuit. No lawsuit or legal action of any kind related to eligibility, enrollment, or any benefit decision may be filed by

you in a court of law or in any other forum until you have exhausted the applicable internal appeals procedure described in this Booklet.

LEGAL NOTICES

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

You may select to have a relationship with a Primary Care Physician (PCP), however, designation of a PCP and referrals to a participating specialist are not required under this Plan option. We encourage you to continue a relationship with a PCP who participates in the Anthem network. For information on locating participating PCP's, contact the telephone number on the back of your medical Identification Card or refer to the Anthem website, www.anthem.com.

Access to Obstetrical and Gynecological (OB/GYN) Care

You do not need prior authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our 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, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your medical Identification Card or refer to the Anthem website, www.anthem.com.

Other Legal Notices

Genetic Information Nondiscrimination Act (GINA)

The Plan will not:

- adjust plan contribution amounts or premiums on the basis of genetic information,
- request or require you or any of your family members to undergo a genetic test, or
- request, require, or purchase genetic information for underwriting purposes, or with respect to any individual prior to such individual's enrollment in the plan.

"Genetic information" includes your genetic tests, the genetic tests of your family members, and your family medical history.

Patient Protection and Affordable Care Act (PPACA)

The Plan is required to comply with the Patient Protection and Affordable Care Act of 2010 ("PPACA"). The PPACA makes a number of changes to existing federal laws that impact group health plans. The Plan will comply with all of these new mandates, as required under the PPACA.

Mental Health Parity and Addiction Equity Act

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

of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance, and out of pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.

Statement of Rights under the Women's Health and Cancer Rights Act of 1998

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

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

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

Statement of Rights under the Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act provides that group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, health plans may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

Special Enrollment Notice

Notice for Eligible Current Employees: If you acquire a new dependent, become eligible due to one of the "loss of eligibility for coverage" circumstances below, exhaust COBRA coverage, or gain eligibility for certain premium assistance described below, you may enroll in this plan during a "Special Enrollment Period" instead of waiting until the next annual open enrollment period. The Program Administrator determines whether the loss of eligibility for coverage is due to a qualifying reason after reviewing required documentation. Loss of eligibility for coverage does not include voluntary termination of the coverage, termination of coverage due to failure to pay required premiums, or termination of the coverage for cause.

New Dependent. If you have a new dependent as a result of marriage, birth, adoption, placement for adoption or appointment as a foster parent, you may be able to enroll yourself and your new dependents in the Plan. However, you must request the enrollment form from your employer and provide the completed form and all required documentation to your employer within 31 days after the marriage, birth, adoption, appointment, or placement for adoption.

Loss of Eligibility for Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your eligible dependents in the Plan if you or those dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage.) However, you must request the enrollment form from your employer and provide the completed form and all required documentation to your employer within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

Exhaustion of COBRA Coverage. If you decline enrollment for yourself or for an eligible dependent

(including your spouse) while COBRA coverage is in effect, you may be able to enroll yourself or those dependents in the Plan when the **entire** COBRA coverage period is exhausted. Loss of COBRA enrollment of coverage does not include voluntary termination of the coverage or termination of COBRA enrollment coverage due to failure to pay required premiums. However, you must request the enrollment form from your employer and provide the completed form and all required documentation to your employer within 31 days after the end of COBRA coverage.

Loss of Eligibility Under Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage. However, you must request the enrollment form from your employer and provide the completed form and all required documentation to your employer within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

Eligibility for Premium Assistance Subsidy through Medicaid or a State Children's Health Insurance. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program that could be used to reduce the cost of the Plan, you may be able to enroll yourself and your dependents in the Plan. However, you must request the enrollment form from your employer and provide the completed form and all required documentation to your employer within 60 days after the determination of eligibility for such assistance.

New Dependent Special Enrollment Notice for Enrolled Retiree Annuitants:
If you are a Retiree Annuitant enrolled in the Plan, you may not enroll dependents during Open Enrollment. However, if you have a new dependent as a result of marriage, birth, adoption, appointment as a foster parent, or placement for adoption, you may enroll your new dependents during a 31-day Special Enrollment Period. You must request the enrollment form from your former employer and provide the completed form and all required documentation to your former employer within 31 days after the marriage, birth, placement for adoption, appointment, or adoption. You will not be permitted to add dependents outside of the Special Enrollment Period.

Summaries of Benefits and Coverage

You may obtain a Summary of Benefits and Coverage for each Plan option offered by your Employer. A Summary of Benefits and Coverage will help you understand the plan option and compare it to other options available to you. The Summaries of Benefits and Coverage are available on the web at: www.gacities.com/LHForms. To request a free paper copy of one or more of them, call 1-888-488-4462.

Notice of Privacy Practices for the GMEBS Health and Dental Plans

The notice of privacy practices describes how medical information about you may be used and disclosed by the GMEBS health plan. This notice also explains how you can get access to this information. It is posted at www.gacities.com/LHForms under Annual Notices. You may request a free paper copy of this notice by calling 1-888-488-4462.

Important Creditable Coverage Notice from the Georgia Municipal Employees Benefit System (GMEBS) About Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage with GMEBS and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. This notice is posted at www.gacities.com/LHForms under Annual Notices. You may request a free paper copy of this notice by calling 1-888-488-4462.

IMPORTANT PHONE NUMBERS

Pre-Certification/Predetermination of Medical Necessity
The Hospital, the Physician, or the Participant should call the Medical Claims Administrator: 1-855-343-4851

The Medical Claims Administrator's Member Service Call Center
If you have a member service question for the Medical Claims Administrator, please call:
1-855-397-9267

Out-of-State, In-Network Provider Directory Assistance
If the Participant is out of state and needs service, dial this number:
1-800-810-BLUE
(2583)

Mental Health Care and Substance Abuse Treatment
You may access the mental health network by calling the Medical Claims Administrator:
1-800-292-2879

24/7 Nurse Line
You may access the 24/7 Nurse Line for urgent or immediate care consultation by calling:
1-888-724-Blue (2583)

The Pharmacy Claims Administrator's (Aetna) Customer Service Call Center
If you have a customer service question about pharmacy benefits, please call the Pharmacy Claims Administrator: 1-866-319-4861

Program Administrator's Address
Any forms, notices or correspondence related to enrollment or eligibility for the Plan should be sent to Georgia Municipal Association, the Program Administrator for the Plan as follows: GMEBS Health Plan, P.O. Box 105377, Atlanta GA 30348. Forms, notices or correspondence related to COBRA should be sent to the Program Administrator unless your COBRA notice instructs you to correspond with a different COBRA Administrator**.**

How to Obtain Language Assistance

The Claims Administrators are committed to communicating about the health plan, regardless of language. The Medical Claims Administrator employs a language line interpretation service for use by all of its Member Service call centers. Simply call the Member Service phone number on the back of your Medical Identification 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.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling customer service at the number on the back of your medical Identification Card. Likewise, if you require language assistance from the Pharmacy Claims Administrator, please call the member services number located on your pharmacy Identification Card, and you will be connected with the language line if needed.

1. Eligibility and Enrollment

1.A Eligibility Information

The term “Employee” is used throughout this booklet. “Employee” can mean either a current employee or a former employee (a Retiree Annuitant) who is eligible to enroll in this Plan option as a result of employment (past or present) with the Participating Employer. Some booklet provisions will clarify whether they relate to current Employees or to Retiree Annuitants.

Eligibility as a Current Employee

This booklet describes the benefits an Employee who meets the definition of a Regular Employee may receive under this Plan option. An enrolled current Employee is also called a Participant. A Participating Employer’s current Employee is eligible for coverage as a Regular Employee if he or she resides in the United States and is employed in a salaried or hourly rated position that requires 30 Hours of Service per week or more and is expected to last at least 48 weeks. An Hour of Service is an hour for which an employee is paid, or is entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment, due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Participating Employers that are cities may also offer coverage to elected or appointed members of the Participating Employer’s governing authority, chief and associate legal officers, and municipal judges who do not otherwise meet the definition of a Regular Employee if the city elects on its Declaration Page to offer coverage to elected or appointed members of the governing authority.

Participating Employers that are “Applicable Large Employers” within the meaning of the Patient Protection and Affordable Care Act ("PPACA") may or may not offer coverage to workers who are not otherwise eligible for coverage, but whom the Participating Employer has identified as a “Full-Time Employee” as defined by the PPACA. The Applicable Large Employer is solely responsible for determining whether to offer coverage to such individuals.

The Participating Employer may change eligibility class elections at any time or end coverage at any time. All of these Employees are referred to as Current Employees in this booklet.

Eligibility as a Retiree Annuitant

If a Participating Employer has elected to offer Retiree Annuitant Coverage under this Plan option by filing an approved declaration electing to provide Retiree Annuitant Coverage under the GMEBS Health Plan for Active Employees (“Retiree Annuitant Coverage Declaration Page) with the Program Administrator, this booklet describes the benefits a Retiree Annuitant may receive. Eligibility requirements for coverage as a Retiree Annuitant are set forth on the Participating Employer’s Retiree Annuitant Coverage Declaration Page. Information about how much Retiree Annuitant coverage costs is solely maintained by the Participating Employer. A former employee may only be eligible for coverage as a Retiree Annuitant if he or she was enrolled in the Plan immediately before termination of employment and commenced receiving a defined benefit plan annuity under the Participating Employer’s defined benefit retirement plan immediately after termination of employment.

Eligibility as a Dependent

Covered Dependents are also called Participants. Coverage is available to dependents of Regular Employees and current members of the Participating Employer's governing authority (if elected by the Participating Employer) only if and to the extent that the Participating Employer elects on its Declaration Page to offer dependent coverage. Coverage is available to dependents of Retiree Annuitants only if and to the extent that the Participating Employer elects on its Retiree Annuitant Coverage Declaration Page to offer them coverage. Please check with your Participating Employer to see which classes of dependents are eligible, if any.

Eligible Dependents include the following classes, if they are included as Eligible Dependents under the Participating Employer's Declaration Page or Retiree Annuitant Declaration Page:

The Employee's Spouse - "Spouse" shall mean, effective before June 26, 2015, a person of the opposite sex from that of the Employee who is joined with the Employee in a marriage recognized under Georgia law." Effective on and after June 26, 2015, "Spouse" shall mean a person who is lawfully joined with the Employee in a marriage which is recognized under the laws of any state or foreign jurisdiction, whether opposite-sex or same-sex and regardless of whether or not the spouse resides in the state or foreign jurisdiction in which such marriage occurred.

Dependent Children Until Age 26 - This includes the Employee's children until they attain age 26. For purposes of this provision, the term "children" includes biological children, stepchildren, adopted children, and foster children (See definitions of "adopted children" and "foster children" below). Children under age 26 for whom the Employee has legal responsibility to provide health insurance coverage resulting from a National Medical Support Notice or other valid court decree will also be considered children of the Employee (See " National Medical Support Notices" below).

Disabled Children After Reaching Age 26 - The Employee's unmarried children who are mentally or physically disabled prior to the age of 26, so incapacitated as to be incapable of self-sustaining employment, and chiefly dependent on the Employee for support, will be considered eligible regardless of age. However, to be eligible for coverage as a disabled dependent after reaching age 26, the dependent must have been covered under the Plan immediately prior to reaching age 26. Certification of disability is required to be provided to the Program Administrator within 31 days after attainment of age 26. A certification form is available from the Participating Employer or on www.gacities.com/LHForms.

The Employee may be required to provide proof of the child's continued eligibility on a periodic basis in order to maintain coverage for the child.

Documentation Verifying Dependent Status

To verify eligibility for all dependents, the Program Administrator requires documentation to verify the relationship at the time of the dependents' enrollment, including but not limited to birth certificates, adoption records, and marriage certificates. Additionally, coverage under the Plan may be denied or discontinued for Employees' family members if required documentation is not provided when requested by the Program Administrator or the Claims Administrator. The Program Administrator will require documentation of common law marriage in a state that recognizes such marriages to be in the form of a court ruling or state-issued declaration recognizing the marriage.

If an Employee and spouse are both enrolled as Employees under the Plan, either the Employee or spouse, but not both, can apply for family coverage. If the spouse with family

coverage stops being enrolled as an Employee, the other spouse may become enrolled for family coverage by applying within 31 days.

Definitions

- Adopted Children: Adopted children are legally adopted children from the date the Employee assumes legal responsibility (including children placed with the Employee for adoption). Placement for adoption means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.

- Foster Children: Foster children are children who are placed with the Employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. The judgment, decree, or court order does not need to reference foster care as long as it authorizes placement of the child with the Employee and creates a valid parent/child or legal guardian/legal ward relationship between the Employee and the child. Foster children for whom an Employee assumes legal responsibility are not covered automatically. In order for a foster child to be enrolled, the Employee must provide confirmation of a current, valid court-ordered placement of the child with the Employee to the Program Administrator. Such confirmation must be furnished at the Employee's expense and the child must be enrolled within 31 days after establishment of the placement. If the above requirements are met, the effective date of coverage will be the first of the month following or coinciding with application for coverage of the foster child. If enrollment is not completed within the 31-day period, the foster child will be treated as a Late Enrollee (if the parent is a Current Employee), or will not be able to enroll in the Plan in the future (if the parent is a Retiree Annuitant).

Coverage for Children Pursuant to National Medical Support Notice or Valid Court Order

National Medical Support Notice.

Federal law provides specific rules for the coverage of children that are the subject of a National Medical Support Notice (NMSN). Pursuant to these rules, a child for whom an Employee has received a NMSN, which has been determined by the Program Administrator to be qualified will be considered a Dependent Child of the Employee (see "Coverage for the Employee's Dependents" above for definition of Dependent Children).

Upon receipt of a NMSN, the Program Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is qualified and if the child is eligible to be enrolled. The Participating Employer will subsequently notify the Employee and the child(ren) of the determination.

A NMSN cannot require the Plan to provide any type or form of benefit that it is not already offering. However, coverage will be provided to the extent necessary to comply with the Georgia Child Support Recovery Act.

Valid Court Order.

If an Employee is otherwise legally responsible to provide health insurance coverage for a child pursuant to a valid court decree, the child will be considered an eligible dependent and the Employee may enroll the child within 60 days after establishment of legal responsibility pursuant to the court decree. In order to complete enrollment, the Employee must provide a copy of the court order to the Program Administrator at the Employee's expense. If enrollment is not completed within 60 days, the child will be considered a Late

Enrollee. (See **"Late Enrollees (for Current Employees only)"** below).

Eligibility Waiting Period

To become eligible for benefits under this Plan, an Employee must first satisfy the eligibility waiting period set forth in the Participating Employer's Declaration Page. An Employee must also enroll himself and any eligible dependents in a timely manner in accordance with the enrollment rules of the Plan. Enrollment and coverage under the Plan is contingent upon payment of any required contributions toward the cost of coverage. (See **"Enrollment Information"** below).

1.B Enrollment Information

New Group Enrollees (When Participating Employer First Starts Participation in the Plan)

Current Employees: Employees and their eligible dependents who were enrolled under the Participating Employer's former group plan immediately before the former plan was replaced with this Plan will generally be eligible to enroll for coverage on the date the Participating Employer's group coverage under this Plan becomes effective. Initial Enrollees do not have to satisfy the eligibility waiting period. Those who are eligible to enroll as Initial Enrollees and who are Current Employees, but who do not enroll within 31 days after group coverage under this Plan becomes effective will be treated as Late Enrollees unless they qualify for special enrollment (See **"Late Enrollees"** and **"Special Enrollment"** below).

Retiree Annuitants: Retiree Annuitants and their eligible dependents who were enrolled under the Participating Employer's former group plan immediately before the former plan was replaced with this Plan will generally be eligible to enroll for coverage on the date the Participating Employer's group coverage under this Plan becomes effective and the Participating Employer's Retiree Annuitant Declaration Page is approved. These Retiree Annuitants and dependents must enroll within 31 days after group coverage under this Plan becomes effective. If a Retiree Annuitant does not enroll a dependent by the deadline, he or she may not add the dependent at a later date except in accordance with the Special Enrollment Rules for Retiree Annuitants below.

New Hires

Newly hired Employees must submit an Application for Enrollment no later than **31 days** after the Employee has satisfied the Participating Employer's eligibility waiting period. Applications for enrollment may be obtained from the Employer. If the Employee does not enroll him or herself and any eligible dependents within this time period, they will be treated as Late Enrollees, unless they qualify for special enrollment (See **"Late Enrollees (for Current Employees Only)"** and "**Special Enrollment for Current Employees"** below).

New Retiree Annuitants

Retiree Annuitants must submit an Application for Enrollment as a Retiree Annuitant no later than 60 days following termination of employment with the Participating Employer. Applications for enrollment may be obtained from the Participating Employer. If the Retiree Annuitant does not enroll him or herself at this time, he or she will not be able to participate in the Plan at a later date. If the Retiree Annuitant enrolls by the deadline, but does not enroll eligible Dependents, the eligible Dependents may only enroll at a later date if permitted under the Special Enrollment for Retiree Annuitants section below. (See "**Special Enrollment for Retiree Annuitants**" below).

When Coverage Begins

Except as stated below, coverage for a new hire begins on the first day of the month immediately following satisfaction of the eligibility waiting period set forth in the Participating Employer's Declaration Page. If an Employee is not actively at work on the date coverage

would otherwise become effective; the effective date of coverage for the Employee and any enrolling eligible dependents will be postponed until the Employee returns to active status. If an Employee is not actively at work due to health status or because the Employee is on leave pursuant to the Family and Medical Leave Act (FMLA), this rule will not apply. For a Retiree Annuitant who has properly enrolled, coverage starts immediately after the date coverage as a current employee ends.

Late Enrollees (for Current Employees Only)

Initial Enrollees, newly hired Employees, and their eligible dependents who are eligible for coverage based on the Employee's current employment, but who do not enroll within 31 days after they first become eligible to enroll are considered Late Enrollees. Late Enrollees must wait until the next open enrollment period to apply for enrollment in the Plan (See **"Open Enrollment for Current Employees"** below). However, Late Enrollees may be able to enroll before the next open enrollment period if they qualify for special enrollment (See **"Special Enrollment for Current Employees"** below).

Open Enrollment for Current Employees

The Plan permits late enrollment for Current Employees only one time each year, during "Open Enrollment." Late Enrollees will have a window period of a few weeks (usually during the fall), to enroll in the Plan for an effective date of January 1st of the next year. Please check with your Employer to see when Open Enrollment begins and ends.

If a Late Enrollee does not enroll during the open enrollment period, he or she may not apply for enrollment until the next open enrollment period, unless the Late Enrollee qualifies and applies for special enrollment before then.

During Open Enrollment, covered Current Employees may elect to change their Plan option to any option made available by the Participating Employer. Covered Current Employees may also elect to change from single to family coverage (and vice versa) during the open enrollment period, depending on the Plan options provided by their Employer.

Open Enrollment for Retiree Annuitants

During Open Enrollment, enrolled Retiree Annuitants may change coverage to any Plan option offered by the Participating Employer to Retiree Annuitants (if a change is desired). Available options are stated on the Participating Employer's current Retiree Annuitant Declaration Page. Enrolled dependents may be removed from the Plan during Open Enrollment as well. However, Retiree Annuitants may not add dependents during the Open Enrollment unless a Special Enrollment event permits the addition.

Special Enrollment for Current Employees

Please see the Special Enrollment Notice in the Notices Section of this Booklet. Employees and their eligible dependents may be able to enroll without having to wait for the next open enrollment period, if they are otherwise eligible for coverage and if they experience certain "special enrollment" events. Coverage will be provided only for those who have been reported to the Program Administrator and on whose behalf a timely and complete special enrollment application is submitted to the Program Administrator. If an Employee already has "full" family coverage that includes spouse and children and enrolls an additional eligible dependent during a special enrollment period due to a special enrollment event, then no additional premium will be required. However, Employees with single coverage must pay the additional premium for dependent and/or full family coverage in order to complete special enrollment for eligible dependents as required by the Participating Employer. Below is a description of the special enrollment events and the rules applicable to each.

There are different special enrollment rules for Retiree Annuitants. See **"Special Enrollment for Retiree Annuitants"** below.

Special Enrollment Events (for Current Employees Only)

A. Loss of Other Group Health Plan Coverage or Health Insurance (for Current Employees Only)

If an Employee initially declines coverage under this Plan for himself (or for an eligible dependent) because of other group health plan coverage or health insurance coverage, the Employee may be able to enroll himself or the eligible dependent upon loss of the other coverage. In order for a dependent to be eligible for enrollment, the Participating Employer must offer coverage to the class of dependents to which the dependent belongs (See **"Eligibility as a Dependent"** above). A completed application for special enrollment and proof of a qualifying loss of other coverage must be submitted within 31 days after the other coverage ends. To qualify for special enrollment due to loss of other coverage, the Employee or eligible dependent must have lost health insurance coverage (medical benefits offered through a licensed health insurance company) or coverage under a group health plan (a health plan provided to employees and dependents) for one of the following qualifying reasons:

When the other coverage was not provided through COBRA -

- He or she became ineligible for the other coverage due to legal separation, divorce, attainment of maximum age for child coverage, death of an employee, termination of employment, reduction in hours of employment, and any loss of eligibility for coverage after a period measured by reference to any of the foregoing; or
- He or she became ineligible because the other coverage was through an HMO in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, and the individual lost eligibility because he or she no longer resides, lives, or works in the service area;
- He or she became ineligible because the other coverage was through an HMO in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, and the individual lost eligibility because he or she no longer resides, lives, or works in the service area and no other group health plan package is available to the individual; or
- He or she became ineligible because health benefits were eliminated for a class of similarly situated individuals that includes the individual; or
- All employer contributions toward the cost of the other coverage have been terminated (even if he or she chose to continue coverage by paying the entire amount.)

When the other coverage was provided through COBRA -

- The entire COBRA coverage period has been exhausted

Special enrollment **is not** available if the other coverage was: accident-only coverage, disability income insurance, coverage issued as a supplement to liability insurance, liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics or similar coverage for which benefits for medical care are secondary or incidental to other insurance benefits. In addition, special enrollment is not available if qualifying other health coverage is lost because of failure to pay for it, or for cause, such as making a fraudulent claim, or because such coverage was voluntarily dropped. The Employee or eligible dependent is responsible for providing the Program Administrator with proper evidence that the other coverage was group health plan or health insurance coverage and was lost for a qualifying reason.

Special Enrollment Period - The special enrollment period ends no later than **31 days** after the date qualifying other coverage was lost for a qualifying reason. If the Employee or eligible dependent is not enrolled within this period, then the right to special enrollment as a result of the loss of other coverage will be forfeited. In such case, the Employee or eligible dependent

will be treated as a Late Enrollee and will have to wait until the next open enrollment period to enroll. (See **"Open Enrollment for Current Employees"** above).

Effective Date of Coverage - If a special enrollment application is submitted in a timely manner, then coverage for a special enrollee who has lost other coverage will become effective on the first day of the month following submission of the completed enrollment application, required documentation, and payment of any required contribution. Coverage will be subject to the active work requirements of the Plan (See **"Employees Not Actively at Work"** above).

B. New Dependents (Current Employees Only)

The special enrollment rules also allow Employees to enroll themselves and certain "new" eligible dependents without having to wait until the next open enrollment period under certain circumstances. Coverage is available under the following circumstances, if the Participating Employer offers coverage to the class of dependents to which the "new" dependent belongs (See **"Eligibility as a Dependent"** above):

- If an Employee marries, the Employee may enroll his new spouse, himself, and any eligible dependents if not previously covered.
- If an Employee acquires a new eligible dependent child by birth, adoption, placement for adoption, or marriage (stepchild), the Employee may enroll his new eligible dependent child. If the Employee initially declined enrollment for himself, his spouse, or any other eligible dependents, the Employee and any eligible dependents may also enroll at this time.

Special Enrollment Period - To qualify for special enrollment, the Employee and any eligible dependents must enroll within **31 days** of the event (marriage, birth, adoption, or placement for adoption) that triggers the right to special enrollment. If the Employee or eligible dependent is not enrolled within this period, then the right to special enrollment will be forfeited. The Employee or eligible dependent will be treated as a Late Enrollee and will have to wait until the next open enrollment period to enroll. (See **"Open Enrollment"** above). **Note:** Special rules apply with respect to enrollment of a dependent child pursuant to a National Medical Support Order or a valid court decree (See "**Coverage for Children Pursuant to National Medical Support Notice or Valid Court Order"** above)

Effective Date of Coverage - If the event triggering special enrollment is the Employee's marriage, coverage for those enrolled due to the marriage will become effective on the date of the marriage, subject to active work requirements of the Plan (See **"When Coverage Begins"** above) and if administratively feasible.

If the event triggering special enrollment is the birth, adoption, or placement for adoption of an eligible dependent child, coverage for those enrolled will become effective as of the date of birth, adoption, or placement for adoption. An eligible newborn or adopted child is covered automatically for 31 days from the moment of birth, adoption, or placement for adoption. However, if the Employee has single coverage only, the Employee must complete special enrollment and pay the required additional premium for family coverage within 31 days after the birth, adoption, or placement for adoption in order to continue coverage for the child beyond the 31-day period. ***If the Employee already has family coverage, no additional premium will be required. However, the Employee must still enroll the child within 31 days.***

C. Loss of Eligibility Under Medicaid or CHIP or Eligibility for Premium Assistance (Current Employees Only)

The special enrollment rules also allow current Employees to enroll themselves and eligible dependents without having to wait until the next open enrollment period under the following circumstances:

- If the Employee and his eligible dependents are covered by Medicaid or the State children's health insurance plan ("CHIP") and coverage under such plan is lost due to a loss of eligibility for such coverage, the Employee may enroll himself and his eligible dependents.
- If the Employee and his eligible dependents become eligible for premium assistance with respect to coverage under this Plan under Medicaid or CHIP (including any waiver or demonstration project conducted under or in relation to such plan), the Employee may enroll himself and his eligible dependents.

Special Enrollment Period

To qualify for special enrollment, the Employee and any eligible dependents must enroll within 60 days of the event (**loss of coverage under Medicaid and/or CHIP or eligibility for premium assistance**) that triggers the right to special enrollment. If the Employee or eligible dependent is not enrolled within this period, then the right to special enrollment will be forfeited. The Employee or eligible dependent will be treated as a Late Enrollee and will have to wait until the next open enrollment period to enroll.

Effective Date of Coverage

If a special enrollment application is submitted in a timely manner, then coverage for a special enrollee who has lost other coverage **under Medicaid or CHIP, or who has become eligible for premium assistance with respect to this Plan,** will become effective on the first day of the month following submission of the completed enrollment application and payment of any required contribution. Coverage will be subject to the active work requirements of the Plan (See **"When Coverage Begins"** above).

Special Enrollment for Retiree Annuitants.

New dependents of Retiree Annuitants and eligible dependents of Retiree Annuitants who were not enrolled when first eligible may be able to enroll if the enrolled Retiree Annuitant experiences a special enrollment event. Coverage will be provided only if a completed special enrollment application is submitted to the Program Administrator by the applicable deadline.

If a Retiree Annuitant already has family coverage and enrolls an additional eligible dependent during a special enrollment period, then no additional premium will be required. However, Retiree Annuitants with single coverage must pay the additional premium in order to complete special enrollment for eligible dependents. Below is a description of the special enrollment events and the rules applicable to each.

Special Enrollment Events for Retiree Annuitants

Enrolled Retiree Annuitants who acquire new dependents as a result of marriage, birth, adoption/placement for adoption (a “Special Enrollment Event”) may make the following changes if a complete benefit change form (and required documentation) is submitted to the Program Administrator within 31 days of the Special Enrollment event:

- Marriage – Retiree may add the new spouse and any children who meet the definition of a dependent child (See “Eligibility as a Dependent”) solely as a result of the marriage.
- Acquire New Dependent Child – Retiree may add the new child and an existing spouse.

If the eligible dependent is not enrolled within the 31 day period, then the right to special enrollment is forfeited.

Effective Date of Coverage - If the event triggering special enrollment is the Retiree Annuitant's marriage, coverage for those enrolled due to the marriage will become effective on the date of the marriage.

If the event triggering special enrollment is the birth, adoption, or placement for adoption of an eligible dependent child, coverage for those enrolled will become effective as of the date of birth, adoption, or placement for adoption. An eligible newborn or adopted child is covered automatically for 31 days from the moment of birth, adoption, or placement for adoption. However, if the Retiree Annuitant has single coverage only, the Retiree Annuitant must submit the benefit change form and required documentation and pay the required additional premium for family coverage within 31 days after the birth, adoption, or placement for adoption in order to continue coverage for the child beyond the 31-day period. If the Retiree Annuitant already has family coverage, no additional premium will be required. However, the Retiree Annuitant must still enroll the child and provide required documentation within 31 days.

Nondiscrimination

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

1.C Eligibility and Enrollment Appeals Procedures

The Program Administrator has discretion to interpret the terms of the Plan that pertain to eligibility for benefits, and the Program Administrator's decision regarding eligibility is final. If you believe that a mistake has been made related to enrollment or eligibility for the Plan, contact the Program Administrator in writing at:

GMEBS Health Plan Eligibility and Enrollment Appeals
P.O. Box 105377
Atlanta, Georgia 30348

Include copies of all information that supports your assertion. The Program Administrator will review the information you submit and the relevant Plan Documents, and will send you a written response to your request within 45 days. If you disagree with the written response, you may appeal the decision by writing "GMEBS Health Plan Eligibility and Enrollment Appeals Decision Review" at the above address within ninety (90) days of the date on the written response.

2. When Coverage Terminates and Continuation of Coverage

2.A When Coverage Terminates

Termination During a Hospital Stay

If a Participant is receiving covered care in the Hospital at the time coverage terminates for reasons other than the termination of this Plan, or failure to pay the required contributions, benefits for Hospital Inpatient care will be provided only to the extent available for that Hospital stay.

When Coverage Terminates for Current Employees and Their Dependents

Coverage for a current Employee will end on the earliest of:

- The end of month in which the Employee no longer meets the definition of a Regular Employee or is no longer an elected or appointed member of the Participating Employer's Governing Authority;
- The termination of the Employee's status as a "Full-Time Employee" as defined by the Affordable Care Act, if coverage was offered to the Employee solely as a result of the Employer's determination that the Employer is an "Applicable Large Employer" (as defined by the Affordable Care Act) and the Employee met the definition of a "Full-Time Employee" under the Affordable Care Act.
- The end of the last period for which a required Employer or Employee contribution is paid
- The date the Participating Employer no longer participates in the Plan.
- The date the Plan is terminated by the Plan Sponsor; or
- The date coverage is terminated for a class of persons to which the Employee belongs.

Coverage for an eligible dependent of a current Employee will end on the earliest of:

- The date the Employee's coverage ends for any reason;
- The end of the month in which the dependent no longer qualifies for dependent coverage under the Plan (e.g., due to divorce from Employee or due to an eligible dependent child reaching age 26 or otherwise losing status as an eligible dependent); or
- The date coverage is terminated for a class of persons to which the dependent belongs.

When Coverage Terminates for Retiree Annuitants and Their Dependents

Coverage for a Retiree Annuitant will end on the earliest of:

- The end of the month in which the Retiree Annuitant turns age 65 or becomes eligible for Medicare (unless the Participating Employer's Retiree Annuitant Coverage Declaration Page expressly states otherwise);
- The end of the last period for which the required Employer and Employee contributions are paid;
- The date the Participating Employer no longer offers Retiree Annuitant Coverage in the Plan;
- The date the Participating Employer no longer offers the Plan to current Employees;
- The date the Plan is terminated by the Plan Sponsor;
- The date Retiree Annuitant Coverage is terminated by the Plan Sponsor; or
- The date coverage is terminated for a class of persons to which the Retiree Annuitant belongs.

Unless expressly stated otherwise in the Participating Employer's Retiree Annuitant Declaration Page, coverage for an eligible dependent of a Retiree Annuitant will end on the earliest of:

- The date the Employee's coverage ends for any reason;
- The end of the month in which the dependent no longer qualifies for dependent coverage under the Plan (e.g., due to divorce from the Retiree Annuitant or due to an eligible dependent child reaching age 26 or otherwise losing status as an eligible dependent); or
- The date coverage is terminated for a class of persons to which the dependent belongs.

2.B COBRA Continuation Coverage

COBRA Continuation Coverage for Current Employees and their Dependents

Under the federal COBRA law, employers are required to give enrolled employees and dependents the opportunity to elect a temporary extension of health coverage (referred to as "COBRA" coverage) when their regular coverage would otherwise end due to certain "qualifying events."

You must have been actually enrolled in the Plan on the day before your qualifying event to be eligible for COBRA coverage (except for newborn and adopted children born or placed for adoption within the COBRA coverage period - see below). The Program Administrator reserves the right to verify COBRA eligibility status and to terminate COBRA coverage retroactively if you are determined to be ineligible for COBRA, or if there has been a material misrepresentation of the facts in connection with your coverage.

<u>COBRA Qualifying Events for Enrolled Current Employees</u>
Enrolled current Employees may elect COBRA continuation coverage if they lose their regular coverage due to the following:

- Termination of employment with the Participating Employer (for reasons other than gross misconduct); or
- A reduction in their hours of employment.

<u>COBRA Qualifying Events for Enrolled Dependents of Current Employees</u>
Enrolled dependents may elect COBRA continuation coverage if their regular coverage under the Plan ends because:

- The Employee's employment with the Participating Employer is terminated (for reasons other than gross misconduct);
- The Employee's hours of employment are reduced;
- The Employee dies;
- The Employee is divorced from the enrolled dependent spouse (note – if the Employee reduces or eliminates coverage for the dependent spouse in anticipation of divorce, and the divorce later occurs, then the divorce may be considered a qualifying event even if the spouse was not enrolled at the time of the divorce); or
- The enrolled dependent child no longer qualifies as an eligible dependent.

COBRA Continuation Coverage for Dependents of Retiree Annuitants

Retiree Annuitants are not able to continue coverage under COBRA once their coverage as a Retiree Annuitant in the Plan ends. Enrolled Dependents of Retiree Annuitants may elect COBRA continuation coverage if their coverage under the Plan ends due to certain "qualifying events."

You must have been actually enrolled in the Plan on the day before your qualifying event to be eligible for COBRA coverage (except for newborn and adopted children born or placed for adoption within the COBRA coverage period - see below). The Program Administrator reserves the right to verify COBRA eligibility status and to terminate COBRA coverage retroactively if

you are determined to be ineligible for COBRA, or if there has been a material misrepresentation of the facts in connection with your coverage.

COBRA Qualifying Events for Enrolled Dependents of Retiree Annuitants

Enrolled dependents of Retiree Annuitants may elect COBRA coverage if their coverage under the Plan ends because:

- The Retiree Annuitant turns age 65 or becomes eligible for Medicare
- The Retiree Annuitant dies
- The Retiree Annuitant is divorced from the enrolled dependent spouse (note – if the Retiree Annuitant reduces or eliminates coverage for the dependent spouse in anticipation of divorce, and the divorce later occurs, then the divorce may be considered a qualifying event even if the spouse was not enrolled at the time of the divorce); or
- The enrolled dependent child no longer qualifies as an eligible dependent.

Notifications and Elections

Required Notifications for Current Employees and Their Dependents

Under COBRA, enrolled current Employees and their dependents have the responsibility to provide the Program Administrator with written notice of **divorce or of a child losing eligible dependent status under the Plan.** This notification must be made within 60 days from the date of the event or, if later, the date on which health plan coverage would be lost under the terms of the Plan because of the qualifying event. If this notice is not provided in a timely manner, then any rights to COBRA coverage will be forfeited. Failure to provide such notice may also result in removal or cancellation of coverage under the plan. See the Notice Page in the front of this booklet for the Program Administrator's contact information.

The Participating Employer is responsible to notify the Program Administrator of the other qualifying events listed above (e.g., Employee's loss of eligibility for coverage due to death or due to termination of employment or reduction in hours).

Required Notifications for Retiree Annuitants and Their Dependents

Under COBRA, enrolled Retiree Annuitants and their dependents have the responsibility to provide the Program Administrator with written notice of **death, attainment of age 65 for the Retiree Annuitant, the Retiree Annuitant's enrollment in Medicare, divorce, and loss of a child's status as an eligible dependent.** This notification must be made within 60 days from the date of the event or, if later, the date on which health plan coverage would be lost under the terms of the Plan because of the qualifying event. If this notice is not provided in a timely manner, then any rights to COBRA coverage will be forfeited. Failure to provide such notice may also result in removal or cancellation of coverage under the plan. See the Notice Page in the front of this booklet for the Program Administrator's contact information.

60-Day COBRA Election Period

Once the Program Administrator receives notice of a COBRA qualifying event, the Program Administrator or the COBRA Administrator will in turn notify COBRA-eligible individuals (also known as "qualified beneficiaries") of their right to elect COBRA continuation coverage. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect COBRA continuation coverage. The 60-day election period begins on the date health plan coverage is lost due to the qualifying event, or if later, the date the qualified beneficiary is sent a notice about his right to elect COBRA coverage. This is the maximum period allowed to elect COBRA, and the Plan does not provide for an extension of the COBRA election period beyond what is required by law. If a qualified beneficiary does not elect COBRA continuation coverage within this 60-day election period, then all rights to COBRA coverage will be forfeited.

Nature of COBRA Coverage

COBRA coverage is identical to the coverage provided under the plan to similarly situated Current Employees, or, for Retiree Annuitant dependents, COBRA coverage is identical to the coverage provided under the Plan to Retiree Annuitants. Should coverage change or be modified for similarly situated Current Employees (or, for similarly situated Retiree Annuitants), then the change and/or modification will be made to your COBRA coverage as well.

COBRA Coverage for Current Employees and Dependents – Comparison to Retiree Annuitant Coverage under this Plan

Some Participating Employers currently offer Retiree Annuitant coverage under this Plan. Retiree Annuitant coverage may or may not be subsidized by the Participating Employer. Contact your Participating Employer for information about whether Retiree Annuitant coverage is available and how much it costs. If your Participating Employer offers Retiree Annuitant coverage, it is important to understand the difference between continuing coverage as an active employee under COBRA and electing Retiree Annuitant coverage under this Plan.

COBRA qualified beneficiaries who elect COBRA due to the termination or reduction in hours of a Current Employee:

- have the same special enrollment rights and open enrollment rights as Current Employees;
- can choose any Plan option that is available to Current Employees; and
- may add dependents based on the special enrollment rights and open enrollment rules for Current Employees.

In contrast, Retiree Annuitants:

- are only allowed to add new dependents based on more limited special enrollment and open enrollment rights, and
- may only choose those Plan options that are available to Retiree Annuitants.

If you elect coverage as a Retiree Annuitant or as a dependent of a Retiree Annuitant under this Plan, you waive the COBRA rights that arose due to the termination of employment of the Current Employee.

Similarly, if you choose COBRA coverage, you will not be able to elect Retiree Annuitant coverage under this Plan at a later date. It is possible for the former employee to elect Retiree Annuitant coverage and for his or her dependents to elect COBRA coverage instead.

COBRA Coverage for Current Employees and Dependents – Electing COBRA Does Not Waive Eligibility for Retiree-Only Health Plan if Participating Employer Offers One

Some Participating Employers offer a Retiree-Only Health Plan. Under current rules, electing COBRA continuation of this Plan will not prevent enrollment in such a Retiree-Only Health Plan as long as you enroll in the Retiree-Only Health Plan immediately after COBRA ends. Contact the Participating Employer for more information.

COBRA Coverage Period

18 Month Events (for Current Employees and their Dependents Only)

If the qualifying event causing a qualified beneficiary's loss of regular coverage is termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then the qualified beneficiary will have the opportunity to elect COBRA coverage for up to 18 months.

- Extension of 18- Month Period for Social Security Disability
  If a qualified beneficiary is determined by the Social Security Administration to have been disabled at any time during the first 60 days of COBRA coverage, the qualified beneficiary (and any other members of the family receiving COBRA coverage) may apply for an 11-month extension of the normal COBRA coverage period, (i.e., from 18 to 29 months). The purpose of this provision is to allow disabled qualified beneficiaries to continue their COBRA coverage until they become entitled to Medicare. The Plan may charge up to 150% of the normal COBRA premium for months 19 through 29. To qualify for this extension, you must obtain the disability determination from the Social Security Administration and provide a copy of the determination to the Program Administrator within 60 days after the date of determination and before the normal 18-month COBRA period expires. It is also your responsibility to notify the Program Administrator within 30 days of any final determination by the Social Security Administration that you or any qualified beneficiary in your family is no longer disabled.

- Extension of 18-Month Period for Secondary Events
  The 18-month COBRA period can also be extended for spouses and dependents if, during their first 18 months of COBRA coverage, they experience a second COBRA qualifying event (Employee divorce or death, or a dependent child ceasing to be an eligible dependent). If one of these events occurs, then the 18 month COBRA coverage period can be extended to 36 months. It is the qualified beneficiary's responsibility to provide written notification to the Program Administrator within 60 days of a second qualifying event and before the original 18 month COBRA period expires. Failure to provide such written notice will result in denial of extended COBRA coverage. In no event will COBRA coverage last more than 36 months.

36 Month Events (for Current Employees and their Dependents, and for Dependents of Retiree Annuitants)

If the original qualifying event causing a qualified beneficiary's loss of regular coverage is the Employee's death, divorce, attainment of age 65 or entitlement to Medicare, or a dependent child's ceasing to qualify as an eligible dependent under the plan, then the qualified beneficiary (Current Employee, Dependents of Current Employees, and Dependents of Retiree Annuitants) may elect COBRA coverage for up to 36 months as set forth in the summary below.

If your coverage was terminated in anticipation of a divorce from the Current Employee or Retiree Annuitant that was not yet final, contact the Program Administrator when the divorce is final to determine whether you have COBRA rights based on the divorce.

COBRA Coverage Summary

Initial Qualifying Event that Causes Loss of Coverage	Length of Availability of COBRA Coverage
For Current Employees: Voluntary or Involuntary Termination (other than gross misconduct) or Reduction In Hours	Up to 18 months (may be extended to 29 months under disability extension)
For Dependents of Current Employees: A Covered Current Employee's Voluntary or Involuntary Termination (other than for gross misconduct) or Reduction in Hours	Up to 18 months (may be extended to 29 months under disability extension or may be extended up to 36 months if secondary qualifying event)
Medicare entitlement of Current Employee, followed by Voluntary or Involuntary Termination (for other than gross misconduct), or Reduction in Hours within 18 months	Up to 36 months from the date of Medicare entitlement
Divorce from Covered Current Employee	Up to 36 months
Death of a Covered Current Employee	Up to 36 months
For Dependent Children of Current Employees: Loss of Dependent Child status	Up to 36 months
For Retiree Annuitants: No COBRA Coverage is available	No COBRA Coverage after coverage as Retiree Annuitant ends
For Dependents of Retiree Annuitants: A Covered Retiree Annuitant attains age 65/becomes eligible for Medicare Divorce from Covered Retiree Annuitant Death of Covered Retiree Annuitant Attain age 26	Up to 36 months Up to 36 months Up to 36 months Up to 36 months

COBRA Newborn and Adopted Children

A child who is born to, adopted by, or placed for adoption with a COBRA covered former employee while the former covered employee is receiving COBRA coverage may obtain COBRA coverage. To enroll the child, the former employee must submit an enrollment form to the Program Administrator or the COBRA Administrator within 31 days of the birth or placement for adoption. However, the newborn or adopted child's COBRA coverage cannot be extended beyond the date that the former employee's COBRA coverage ends, unless the child experiences a second COBRA qualifying event. (See "Extension for Secondary Events" above).

COBRA Eligibility and Premiums

A qualified beneficiary will have to pay a monthly COBRA premium which may be adjusted from time to time. Any person may pay the required COBRA premium on behalf of the qualified beneficiary. The COBRA premium is established by the Program Administrator and cannot exceed 102% of the applicable premium (combined employer/employee premium) charged for active employees with similar coverage. If COBRA coverage is extended from 18 months to 29 months due to a Social Security disability, you may be charged up to 150% of the applicable premium during the extended coverage period. There is a maximum grace period of 30 days for the regular monthly COBRA premiums. However, this grace period does not apply to the initial COBRA premium (see below).

Within 45 days after you timely elect COBRA coverage, you must pay the initial COBRA premium. The initial COBRA premium includes the period of coverage from the date you lost coverage through the date of your COBRA election. It also includes any regular monthly premium that becomes due between your election and the end of the 45-day period. There is no grace period for receipt of the initial COBRA premium. If you do not pay the initial premium within 45 days of your election, you will not receive any COBRA coverage.

It is the employees'/dependents' responsibility to pay COBRA premiums to the Participating Employer or the COBRA Administrator listed on the COBRA election notice, if applicable. If COBRA premiums are not paid by the first of the month for which the coverage is effective, the Participating Employer or COBRA Administrator will notify the Program Administrator and coverage will be suspended until the COBRA premiums are paid. The Participating Employer or COBRA Administrator must notify the Program Administrator to reinstate coverage if the COBRA premium is paid after the due date and before the end of the grace period. COBRA coverage must be continuous. There can be no break in coverage or reinstatement of COBRA coverage after it ends. If COBRA premiums are not paid and the grace period expires, COBRA coverage will be forfeited retroactive to the last period for which the applicable required premium was timely paid.

Termination of COBRA Coverage

COBRA coverage will end on the earliest of:

- The last period for which a COBRA continuation premium is paid in a timely manner;
- The date a qualified beneficiary becomes covered under another group health plan after electing COBRA coverage. This rule will not apply in certain limited circumstances (i.e., where the group health plan is a "grandfathered" plan under the Patient Protection and Affordable Care Act of 2010 ("PPACA") and the group health plan imposes an exclusion or limitation with respect to any pre- existing condition of the beneficiary). However, the rule will apply if the pre-existing condition exclusion or limitation is inapplicable or is satisfied by reason of the Health Insurance Portability and Accountability Act of 1996;
- The date a qualified beneficiary enrolls in Medicare (Part A or B);
- With respect to a qualified beneficiary who extends COBRA coverage to 29 months due to a Social Security disability, the date a final determination is made by the Social Security Administration that the qualified beneficiary is no longer disabled.
- The date the Participating Employer ceases to provide any group health plan to any of its employees.
- The date the Plan is terminated; or
- The date the qualified beneficiary exhausts the applicable maximum COBRA coverage period.
- The date the Participating Employer no longer participates in the Plan.

Notification of Address Change

Any correspondence mailed to Participants will be sent to the most current address for the Participant as shown in the records of the Plan. Participants are responsible for providing accurate and complete mailing address information upon their enrollment in the Plan, and for promptly notifying the Program Administrator of any change in their address. If a covered dependent has a different mailing address than that of the Employee, the Program Administrator must be notified of such different mailing address upon enrollment of the dependent and/or when the dependent obtains such different mailing address, as applicable. Failure to do so may result in denial of COBRA continuation coverage.

2.C Military Leave (USERRA) Continuation of Coverage (for Current Employees Only)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), if military leave causes an Employee to lose eligibility for coverage, the Employee may have a right to continuation of health plan benefits while they are on a military leave of absence, subject to the conditions described below.

Under USERRA, if the Employee (or his or her dependents) is covered under this Plan, and if the Employee becomes absent from employment and is no longer employed in a position that meets the eligibility requirements by reason of qualified USERRA military leave, the Employee (or his or her dependents) may have the right to elect to continue health coverage under this Plan.

In order to be eligible for continued coverage during the period that the Employee is away on military leave, the Employee must give reasonable notice to the Participating Employer of his or her military leave. If the USERRA requirements are met, the Employee will be entitled to COBRA-like rights with respect to his or her medical benefits. The Employee and his or her covered dependents can elect to continue coverage under the Plan for a period of 24 months from the date the military leave commences or, if shorter, the period ending on the day after the deadline for the Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay for the entire cost of such coverage, including any dependent coverage. However, if the Employee's absence is less than 31 days, the Employer must continue to pay its portion of the premium and the Employee is only required to pay his or her share of the premium.

When the Employee returns to work, and if the Employee meets the eligibility requirements specified below, USERRA states that the Participating Employer must reinstate prior health coverage. Upon the Employee's return to work, the Employer must take into account the period of military leave in determining whether the Employer's waiting period has been satisfied, even if the Employee did not elect COBRA continuation while on military leave. The USERRA eligibility requirements are: (1) the Employee must give reasonable notice to his or her Employer of the military leave, (2) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances); (3) the Employee must receive no less than an honorable discharge; and (4) the Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any dependent who becomes covered under the Plan by reason of the Employee's reinstatement of coverage.

2.D Family and Medical Leave Act (FMLA) Continuation of Coverage (for Current Employees Only)

If a covered Employee ceases active employment due to an employer-approved leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks in any 12-month period under the same terms and conditions which would have applied had the employee continued in active employment. In order to be eligible for this extension of coverage, the Employee must pay his or her contribution share toward the cost of coverage, if any. Even if a covered Employee chooses not to continue coverage during theFMLA leave of absence, the Employee and his or her covered dependents will be permitted to re-enroll immediately upon return to work in an eligible position, if the Employee returns before the expiration of the FMLA leave period and pays any required contribution to reinstate coverage.

Military FMLA Leave

In accordance with the provisions of the FMLA concerning military FMLA leave, a covered Employee may take up to 26 weeks of FMLA leave during any 12-month period to care for a military service member who is recovering from a serious illness or Injury sustained in the line of duty while on active duty. A covered military service member includes the spouse, son, daughter, foster child, parent or next of kin of the Employee as described in the provisions of the FMLA concerning military FMLA leave. The requirements described above with respect to "regular" FMLA leave also apply with respect to military FMLA leave. If a covered Employee takes both regular FMLA leave and military FMLA leave in a 12-month period, the 26-week limit will apply to the combined total FMLA leave.

COBRA and FMLA Leave

Taking an approved leave under the FMLA isn't considered a COBRA qualifying event that would make an Employee eligible for COBRA coverage. However, a COBRA qualifying event occurs if that Employee or his or her spouse or dependent is covered by the Plan on the day before the FMLA leave begins, does not return to employment in the qualifying position at the end of the FMLA period, or the Employee's employment in an eligible position terminates during the FMLA leave.

3. Coordination of Benefits (COB)

If an Employee, the Employee's spouse, or the Employee's dependents have duplicate coverage under another group plan, any other group medical expense coverage, or any local, state or governmental program, (except school accident insurance coverage and Medicaid) then benefits payable under this Plan will be coordinated with the benefits payable under the other plan. **The total benefits paid by both plans will not exceed 100% of the total charges.**

- "Allowable Expense" means any necessary, reasonable and customary expense at least a portion of which is covered under at least one of the plans covering the person for whom claim is made.
- "Claim Determination Period" means the calendar year.

Order of Benefit Determination

When a Participant has duplicate coverage, claims will be paid as follows:

- Automobile Insurance. Benefits available through automobile insurance coverage will be determined before that of any other plan.
- Non-dependent/Dependent. The benefits of the plan which covers the person as an Employee (other than as a dependent) are determined before those of the plan, which covers the person as a dependent.
- Dependent Child/Parents Not Separated or Divorced. Except as stated below, when this Plan and another plan cover the same child as a dependent of different persons, called **"parents"**:
    - The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year. If both parents have the same birthday, the benefits of the plan, which has covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
    - However, if the other plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- Dependent Child/Parents Separated or Divorced. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - First, the plan of the parent with custody of the child;
    - Then, the plan of the spouse of the parent with custody of the child; and
    - Finally, the plan of the parent not having custody of the child.
    - However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the company obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the company has that actual knowledge.
- Joint Custody. If the specific terms of a court decree state that the parents shall have joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above for "Dependent Child/Parents not Separated or Divorced".

- Active/Inactive Employee. The benefits of a plan that covers a person as an Employee who is neither laid off nor retired (or as that Employee's dependent) are determined before those of a plan that covers that person as a laid-off or retired employee (or as that Employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee or Participant longer are determined before those of the plan that covered that person for the shorter time.

Effect on the Benefits of this Plan

This section applies when, in accordance with the Order of Benefit Determination Rules, this Plan is a secondary plan to one or more other plans. In that event the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" below.

The benefits of this Plan will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expenses under this Plan in the absence of this COB provision; and
- The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

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

Miscellaneous Rights

- Right to Receive and Release Necessary Information. Certain facts are needed to apply these COB rules. The Claims Administrator has the right to decide which facts are needed. It may get needed facts from or give them to any other organization or person.

The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Claims Administrator any facts needed to pay the claim.

- Facility of Payment. A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Claims Administrator will not have to pay that amount again.
- Right of Recovery. If the amount of the payment made by the Claims Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of:
    - the persons it has paid or
    - for whom it has paid; insurance companies; or
    - other organizations.

Coordination of Benefits (COB) with Medicare and Medicare Secondary Payer Rules

Coordination of benefits with Medicare depends on employment status. The differences arise from Medicare Secondary Payer laws, which require this Plan to pay primary to Medicare in certain situations.

Important: To avoid late enrollment penalties under Medicare, **it is very important for anyone who is eligible for Medicare to apply for Medicare Part A (if necessary) and enroll in Medicare Part B during the Medicare Special Enrollment period that follows termination of employment.** Why? Because neither COBRA coverage nor Retiree Annuitant coverage are "coverage due to current employment" that can extend the Medicare Special Enrollment Period, and when COBRA or Retiree Annuitant coverage ends, you will have to pay late enrollment penalties to enroll in Medicare Parts A (if enrollment wasn't automatic) and B. **It is not necessary (and not advisable) to enroll in Medicare Part D.** Why not? Because prescription coverage under this Plan is "creditable coverage" for Medicare Part D. See "Medicare Part D Notice of Creditable Coverage" posted at www.gacities.com/LHForms under Annual Notices.

Retiree Annuitants Age 65 and Over (For Certain Employers only)

Except as set forth below under End Stage Renal Disease below, federal law does not require this Plan to be the primary payer for Retiree Annuitants or their covered spouses. **For almost all Participating Employers, coverage for a Retiree Annuitant under this Plan ends when he or she attains age 65 or becomes eligible for Medicare due to earlier disability, and this paragraph does not apply.** In the rare situation in which a Retiree Annuitant is enrolled in Medicare and is still eligible for this Plan, benefits under this Plan are secondary to Medicare.

Current Employees Age 65 and Over

Except as set forth under End Stage Renal Disease below, federal law requires this Plan to be the primary payer (paying benefits before Medicare) for actively working covered Employees who are entitled to Medicare because they are age 65 or older. This Plan will also be primary and Medicare will be secondary for covered spouses of actively working covered Employees, if the spouse is entitled to Medicare because he or she is age 65 or older, regardless of the age of the actively working covered Employee.

Retiree Annuitants Under 65 – Enrolled in Medicare Due to Disability (For Certain Employers Only)

Except as set forth under End Stage Renal Disease below, federal law does not require this Plan to be the primary payer for Retiree Annuitants or their covered spouses or children. **For almost all Participating Employers, coverage for a Retiree Annuitant under this Plan ends when he or she attains age 65 or becomes eligible for Medicare due to earlier disability, and this paragraph does not apply.** In the rare situation in which a Retiree Annuitant is eligible for Medicare and is still eligible for this Plan, if a Retiree Annuitant or a Retiree Annuitant spouse or child is enrolled in Medicare due to disability, this Plan will be secondary to Medicare Parts A and B (paying benefits only after Medicare).

Current Employees Under 65 – Enrolled in Medicare Due to Disability

Except as set forth under End Stage Renal Disease below, this Plan will be the primary payer (paying benefits before Medicare) for actively working covered Employees who are under age 65 and who are enrolled in Medicare by reason of disability. Generally, the Plan will also be primary and Medicare will be secondary for a covered dependent spouse or child of an actively working covered Employee, if the covered dependent spouse or child is under age 65 and is enrolled in Medicare by reason of disability.

COBRA Qualified Beneficiaries Enrolled in Medicare

Except as set forth under End Stage Renal Disease below, Medicare is the primary payer (before this Plan), and benefits will be coordinated with (and secondary to) Medicare benefits if the qualified beneficiary was enrolled in Medicare before the COBRA qualifying event.

End Stage Renal Disease (Retiree Annuitants, Current Employees, and COBRA Qualified Beneficiaries)

Special Medicare secondary payer rules apply to individuals who have end stage renal disease. Under those rules, this Plan pays primary to Medicare for the first 30 months of eligibility or entitlement to Medicare based on end stage renal disease.

4. Subrogation/ Reimbursement in Case of Third Party Claim

If a Participant incurs medical expenses as the result of Injuries or illness suffered because of the alleged negligence or misconduct of another person or entity, the Participant may have a claim against that person or another party for payment of medical expenses. If this Plan pays benefits for such medical expenses, the Plan will have a lien against, and the first right to receive reimbursement from the Participant for any payment, recovery, settlement, or judgment obtained by the Participant from or against any third party alleged to be at fault for the accident, Injury or illness, the third party's insurer, or any other source, for the amount paid by the Plan. The Participant must repay the Plan for benefits paid on his or her behalf out of the recovery made from the third party, insurer or other source. The "make whole" doctrine will not apply and will not limit the Plan's right to recover amounts paid on the Participant's behalf. The Plan's lien will have first priority over any funds paid to the Participant relative to the Injury or illness and will apply to any amount recovered, whether or not it is designated as payment for medical expenses. This lien will remain in effect until Plan is repaid in full.

The Participant will be required to furnish the Claims Administrator with information and assistance required to enforce this right of reimbursement. The right of reimbursement will not apply to any recovery a Participant obtains from any insurance company under which the Participant is the insured person.

MEDICAL BENEFITS - Administered by Anthem, Inc.

5. How Medical Benefits Work

This Plan option has two sets of benefits: In-Network and Out-of-Network. If you choose an In-Network Provider, you will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If you use an Out-of-Network Provider, you will have to pay more in out-of-pocket costs and you may be subject to Balance Billing. Please see the definition of **Maximum Allowed Amount** for more information.

In-Network Services

You have access to primary and specialty care directly from any In-Network Physician. A referral is not needed.

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level stated in the **Schedule of Benefits**. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Medical Claims Administrator has final authority to decide the Medical Necessity of the service.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with the Claims Administrator to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

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

For services from In-Network Providers:

- You will not be required to file any claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services you get or when you have not followed the terms of this Benefit Booklet.

- Precertification will be done by the In-Network Provider. (See "**Getting Approval for Benefits**" for further details.) Note: In-Network Hospitals sometimes use Out-of-Network Providers, who may include but are not limited to anesthesiologists, pathologists and radiologists. These Out-of-Network Providers are not contracted, so they can bill and collect in excess of the Maximum Allowed Amount. When using an In-Network Hospital, it is recommended that you discuss with the In-Network Hospital any Out-of-Network Providers who may render your care.

For services from Out-of-Network Providers:

When you do not use an In-Network Provider, get care as part of an out-of-network Authorized Service or get care as part of an in-network Authorized Service in which services of an out-of-network provider are required, Covered Services are covered at the Out-of-Network level stated in the **Schedule of Benefits,** unless otherwise indicated in this Benefit Booklet. In addition:

- The Out-of-Network Provider can "Balance Bill" or charge you the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments (See **Definition of Maximum Allowed Amount** for more information);
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary precertification is done. (See "**Getting Approval for Benefits**" for more details.)

Copayment, Deductible and Coinsurance

Whether you see In-Network or Out-of-Network Providers, you will be charged a Copayment or a Deductible and Coinsurance as shown in the **Schedule of Benefits**. For Medical Emergencies, the Copayment is waived if the member is admitted to the Hospital through the emergency room.

Calendar Year Deductible

Before the Plan begins to pay certain benefits, the Deductible must be satisfied. Deductible requirements are stated in the **Schedule of Benefits**. Covered charges during the last three months of a calendar year applied to that year's Deductible can carry over and also apply toward the next year's Deductible.

Calendar Year Day or Visit Maximums

If a particular benefit is subject to a calendar year day or visit maximum, the maximum applies to the **combined** days or visits with in-network and out-of-network providers. There are **not** separate day or visit maximums for in-network and out-of-network providers.

Percentage Payable In-Network & Out-of-Network

After the Deductible is met, the percentage of the Maximum Allowed Amount payable by the Plan is stated in the **Schedule of Benefits**. The percentage of the Maximum Allowed Amount you must pay is also stated in the **Schedule of Benefits**. After you reach the applicable Out-of-Pocket Limit, the Plan pays 100% of the Maximum Allowed Amount for the remainder of the calendar year. Charges in excess of the Maximum Allowed Amount will not be covered.

Out-of-Pocket Calendar Year Maximums (Out-of-Pocket Limit)

Out-of-Pocket Limits are stated in the **Schedule of Benefits**. These include Individual and Family Out-of-Pocket Limits. Deductibles and expenses accumulate separately for each type of Out-of-Pocket Limit (In-Network medical, Out-of-Network medical, In-Network pharmacy, Out-of-Network pharmacy). For example, expenses for In-Network medical care applied to the deductible or paid as co-insurance accumulate to the In-Network medical Out-of-Pocket Limit, and expenses for Out-of-Network prescriptions applied to the deductible or paid as co-pays accumulate to the Out-of-Network pharmacy Out-of-Pocket Limit. Each Family Out-of-Pocket Limit has an embedded individual Out-of-Pocket Limit. That means that all family members' deductible, co-insurance and co-payments associated with that type of Out-of-Pocket Limit count toward the family amount of that Out-of-Pocket Limit, but once any single family member's expenses reach the individual amount for that Out-of-Pocket Limit, the Plan will pay 100% of the Maximum Allowable Amount for that individual's expenses. Co-payments, co-insurance and amounts applied to the deductible count toward the Out-of-Pocket Limits. The following expenses do not count toward meeting the Out-of-Pocket Limits:

- Any additional amount for unauthorized treatment or services or treatment or services that are not Medically Necessary;
- Health care this Plan option does not cover;
- Balance Billed charges (charges in excess of the Maximum Allowed Amount)
- Premiums

No Lifetime Dollar Maximum on Benefits

There are no lifetime dollar maximums on benefits.

6. Getting Approval for Medical Benefits

This Plan option includes the processes of Prior Authorization, Precertification, Predetermination and Post Service Clinical Claims Reviews (defined below) to decide when services should be covered by the Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary in order to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

If you have any questions about the information in this section, you may call the member services phone number on the back of your medical Identification Card.

Types of Requests

- Prior Authorization - In-Network Providers must obtain prior authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. The Medical Claims Administrator may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.
- Precertification - A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Physician must tell the Medical Claims Administrator within 48 hours of the admission. For labor / 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. For all other hospitalizations, precertification is required.
- Predetermination – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. The Medical Claims Administrator will check this Booklet to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Plan option or is Experimental / Investigational as that term is defined in this Benefits Booklet.
- Post Service Clinical Claims Review – A retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical reviews are done for a service, treatment or admission in which the Medical Claims Administrator has a related clinical coverage guideline and are typically initiated by the Medical Claims Administrator. For example, if a Participant is admitted to a Hospital and the admission is determined by the Medical

Claims Administrator not to be Medically Necessary, no benefits will be provided for that Hospital admission and related physician charges.

Making Requests

The provider, facility or attending Physician should contact the Medical Claims Administrator to request a Precertification or Predetermination review. The Medical Claims Administrator will work directly with the requesting provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your medical Identification Card.

The Medical Claims Administrator may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in the Medical Claims Administrator's discretion, such change furthers the provision of cost effective, value based and/or quality services. The Medical Claims Administrator may also exempt your claim from medical review if certain conditions apply.

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

Select In-Network Providers may participate in quality care programs (enhanced personal healthcare) that involve different medical management processes. You may find out whether a health care provider is taking part in certain programs by checking your online provider directory (www.anthem.com "Find a Doctor" link) or by contacting member services at the number on the back of your medical Identification Card. To search for Physicians who participate in these programs, visit www.anthem.com "Find a Doctor," and then refine results using "Participating in Enhanced Personal Healthcare."

The Medical Claims Administrator also may identify certain healthcare 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 Medical Claims Administrator may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to Participants.

The Medical Claims Administrator will use clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines, and other applicable policies to help make Medical Necessity decisions. Medical polices and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. The Medical Claims Administrator reserves the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone number on the back of your medical Identification Card.

Request Categories

- Urgent – A request for Precertification or Predetermination of the Medical Necessity of care or treatment of an injury or illness that, in the view of the treating Provider or any Physician with knowledge of your medical condition, could seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- Prospective – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- Continued Stay Review - A request for Precertification or Predetermination that is conducted during the course of outpatient treatment or during an Inpatient admission.

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

Decision and Notice Requirements

The Claims Administrator will review requests for prior approval of the Medical Necessity of treatment according to the timeframes listed below. Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on your medical Identification Card for additional information.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Urgent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make a decision, the Claims Administrator will tell the requesting provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed or if the information is not complete by the timeframe identified in the written

notice, a decision will be made based upon the information received.

The Claims Administrator will give notice of its decision as required by state and federal law. Notice may be given by the following methods:

- Verbal: Oral notice given to the requesting provider by phone or by electronic means if agreed to by the Provider.

- Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and you or your authorized representative.

Precertification of the Medical Necessity of treatment does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

- You must be eligible for benefits;
- The service or supply must be a Covered Service under this Plan option;
- The service cannot be subject to an exclusion under this Plan option; and
- You must not have exceeded any applicable limits under this Plan option.

Care Received Outside the United States

Except for Emergency care, all medical care outside of the United States must be pre-certified. See General Conditions and Information for more information.

In-Network Precertification

It is the In-Network Provider's responsibility to obtain pre-certification for services that require pre-certification. Neither the Participant nor the Plan will be responsible for any bill in excess of related deductible, Participant's percentage payable amounts and Non-Covered Services. Non-Covered Services are always the Participant's responsibility.

Out-of-Network Precertification

The Participant, the physician or the Hospital must obtain approval for all Hospital admissions to an Out-of-Network Hospital and all other treatment for which precertification is required. This includes Inpatient admissions. If precertification is not obtained, the Plan will not pay any benefits for the service. If precertification is obtained, but your stay exceeds the number of days approved, there will be no benefit payable for the days exceeding the authorized length of stay.

7. Description of Medical Benefits and Services

The following description of benefits and services is subject to the payment terms, conditions, exclusions, limitations and definitions contained in the Plan Documents.

Inpatient Hospital Services

A Participant may receive inpatient treatment at an In-Network or Out-of-Network Hospital. However, higher deductibles and coinsurance or copayment requirements apply if services are received at an Out-of-Network Hospital, as set forth in the **Schedule of Benefits.** Moreover, Participants may be subject to balance billing by Out-of-Network Hospitals or their Physicians for costs that exceed the Maximum Allowed Amount. See the definition of Maximum Allowed Amount for more information. All inpatient services must be pre-certified.

Hospital Inpatient care coverage provides benefits for Medically Necessary services and supplies, including:

Room
Allowance
If a Participant is admitted to the Hospital, coverage is provided for Inpatient care. This includes charges for Semiprivate Room and board and general nursing care. If a Participant stays in a private room, the Plan pays benefits up to the Hospital's most prevalent semiprivate rate. If a Participant is admitted to a Hospital that has only private rooms, the Plan will pay benefits up to the Hospital's most prevalent room rate.

Services and Supplies
The Plan covers services and supplies provided and billed by the Hospital while a Participant is Hospitalized, including the use of operating, recovery, and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered. Convenience items (such as radios, TV's, and telephones) are not covered.

Intensive Care Unit or Cardiac Care Unit
If a Participant is treated in a Hospital's intensive or cardiac care unit, this Plan covers the charges based on the percentage payable of the Maximum Allowed Amount. This Plan will not pay for a regular room charge while a Participant is in a special unit.

Length of Stay
The Medically Necessary length of stay is determined by precertification or other Medical Necessity review.

Outpatient Hospital Services

A Participant may receive outpatient treatment at an In-Network or Out-of-Network Hospital. Certain outpatient services must be pre-certified. Higher deductibles and coinsurance or copayment requirements apply if services are received at an Out-of-Network Hospital, as set forth in the Schedule of Benefits. Moreover, Participants may be subject to balance billing by the Out-of-Network Hospital or its Physicians for costs that exceed the Maximum Allowed Amount.

This Plan option covers expenses incurred for outpatient services for pre-admission tests, surgery, diagnostic x-rays and laboratory services (see **Schedule of Benefits**).

Emergency Room Care

Participants pay the Emergency Room Copayment as shown in the **Schedule of Benefits**. This applies to the Maximum Allowed Amount for the necessary services and supplies you or

your covered dependent receives as an outpatient in an emergency room.

If the emergency room treatment results in admission to the Hospital within 24 hours, the emergency room Copayment will be waived. Emergency room care consists of initial services rendered for the onset of symptoms for a life-threatening medical condition or serious Accidental Injury, which requires immediate medical care. A medical emergency means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson (not a medical professional), possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in: (a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are NOT limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness; severe burns or cuts, uncontrolled bleeding, or convulsions and such other acute conditions as may be determined to be medical emergencies by the Medical Claims Administrator.

Medically Necessary services will be covered whether the care is rendered by an In-Network Provider or an Out-of-Network Provider. Emergency Care rendered by an Out-of-Network Provider will be covered as an In-Network service; however the Participant may be responsible for the difference between an Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Coinsurance, Copayment or Deductible.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be the greatest of:

- The amount negotiated with In-Network Providers for the Emergency service furnished;
- The amount for the Emergency service calculated using the same method the Medical Claims Administrator generally uses to determine payments for Out-of-Network services but substituting the In-Network cost- sharing provisions for the Out-of-Network cost-sharing provisions; or
- The amount that would be paid under Medicare Parts A and B for the Emergency service, without regard to copayments and coinsurance.

Urgent Care Services

Services rendered at Urgent Care Centers are covered as shown in the **Schedule of Benefits**.

Medical and Surgical Care

General care and treatment of illness or Injury, and surgical diagnostic procedures including the usual pre- and post-operative care.

Surgery Performed in a Physician's Office

All outpatient surgical procedures, when provided in a Physician's office, will be covered under the Participant's Physician Office Copayment if services are rendered by an In-Network Provider. Services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements, as stated in the **Schedule of Benefits**.

Outpatient Surgery

Surgery at an In-Network Hospital outpatient department or at an In-Network Freestanding Ambulatory Facility charges are covered as stated in the **Schedule of Benefits**, and must be pre-certified.

Surgery Performed at an Out-of-Network Freestanding Ambulatory Surgery Facility

Any services rendered or supplies provided while you are a patient of or receive services from an Out-of-Network Freestanding Ambulatory Surgery Facility must be pre-certified, and will be payable at 50% of the Maximum Allowed Amount unless the Out-of-Network Freestanding Ambulatory Surgery Facility is contracted with the Medical Claims Administrator.

Assistant Surgeon

Services rendered by an assistant surgeon are covered if Medically Necessary. Assistant surgeon fees are covered at 20% of the Maximum Allowable Amount for the primary surgical service performed.

Reconstructive Surgery

Reconstructive surgery is covered only to the extent necessary to correct the following conditions:

- Restoration of function of any body area which has been altered by disease, trauma, congenital/developmental anomalies or previous therapeutic processes;
- To correct congenital defects of an eligible dependent child that lead to functional impairment;
- To correct medical complications or post-surgical deformity, unless the previous surgery was performed while enrolled in this Plan and was not covered.

Breast Reconstructive Surgery

Covered services are provided following a Medically Necessary mastectomy for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications, including lymphedemas.

This coverage will be provided in consultation with the attending Physician and the patient, and will be subject to the same annual deductibles and Coinsurance provisions that apply for the mastectomy.

Oral Surgery

Includes only the following:

- Fracture of facial bones;
- Lesions of the mouth, lip, or tongue which require a pathological exam
- Incision of accessory sinuses, mouth salivary glands or ducts;
- Dislocations of the jaw;
- Removal of impacted teeth;
- Treatment of temporomandibular joint syndrome (TMJ) or myofacial pain including only removable appliances for TMJ repositioning and related surgery and diagnostic services. Benefits are **not** provided for fixed or removable appliances, which involve movement or reposition of the teeth, or operative restoration of teeth (fillings), or prosthetics (crowns, bridges, dentures).
- Plastic repair of the mouth or lip necessary to correct traumatic injuries or congenital defects; and
- Initial services, supplies or appliances for dental care or treatment required as a result of, and directly related to an accident causing Injury to natural teeth or structure

performed within 180 days of the date of the accident; does not include tooth fracture due to biting or chewing.

Inpatient Private Duty Nursing Services of R.N. or L.P.N.

Care is covered only when no intensive or cardiac care unit is available, and the care needed is beyond the capabilities of the Hospital's floor nurses. Care must be pre-certified as Medically Necessary.

Out-of-Hospital Private Duty Nursing Services of R.N. or L.P.N.

Care must be pre-certified as Medically Necessary.

Limitations for both Inpatient and Outpatient Private Duty Nursing Services of an R.N. and L.P.N.

Services are not covered when:

- requested by, or for the convenience of, the patient or the patient's family;
- services consist primarily of bathing, feeding, exercising, homemaking, moving the patient, giving oral medication, or acting as a companion or sitter;
- the private duty nurse is a relative by blood or marriage or a member of the household of the
- Participant;
- Inpatient services could have been rendered by the Hospital's general nursing staff; or
- outpatient services could be safely rendered by an individual other than a registered nurse (RN)

  or licensed practical nurse (LPN).

Cardiac Rehabilitation

Pre-certification and Individual Case Management required (see below for description of the Individual Case Management Program)

Nutritional Counseling

Pre-certification required. Counseling must be related to the medical management of a disease state. As a Preventive Service (see below), the Plan covers screening for obesity and behavior and nutritional counseling in some circumstances. To be covered as a Preventive Service, the screenings and counseling must be properly coded.

Hemodialysis

The Plan covers reasonable charges for hemodialysis, subject to Coordination of Benefits with Medicare.

Durable Medical Equipment and Medical Devices

Pre-certification may be required. For Out-of-Network services, call Customer Service to see if pre-certification is required. Except as excluded under the "Limitations and Exclusions" section, Durable medical equipment and medical devices are covered when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.

- Is only for use of the patient.
- Is made to serve a medical use.
- Is ordered by a Physician.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by the Medical Claims Administrator. The Plan may limit the amount of coverage for ongoing rental of equipment. The Plan may not cover more in rental costs than the cost of simply purchasing the equipment).

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

This Plan option includes benefits for prosthetics and durable medical equipment and medical supplies for the treatment of diabetes. This Plan option also includes benefits for breast pumps as described in the “Preventive Care” section.

Ambulance Services

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

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

Ambulance services are subject to Medical Necessity reviews. When using an air ambulance, the Claims Administrator reserves the right to select the air ambulance Provider. If you do not use the air ambulance provider selected, the Out-of-Network Provider may bill you for any charges that exceed the Maximum Allowed Amount.

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

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

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

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include 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.

Prosthetic Appliances

Pre-certification may be required. For Out-of-Network services, call Customer Service to see if pre-certification is required. This Plan option includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories;
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes);
- Breast prosthesis (whether internal or external) after a mastectomy, as required by the Women's Health and Cancer Rights Act.

- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care
- Restoration prosthesis (composite facial prosthesis).
- Artificial eyes,
- Arm braces, and
- Leg braces (and attached shoes).

The following items are **excluded:** corrective shoes; dentures, replacing teeth or structures directly supporting teeth, except for traumatic injuries; electrical aids--either anal or urethral; penile implants; hearing aids or hearing devices (other than cochlear implants); hair pieces; implants for cosmetic purposes.

Hospital Visits

The physician's visits to his or her patient in the Hospital, except for usual post-operative visits (see **"Medical and Surgical Care"**). The Plan provides benefits for one daily visit for a Physician during the covered period of confinement.

Benefits for medical care by more than one Physician are not usually provided. Such benefits are only allowed if it can be shown that the supplementary skills of the separate Physician are Medically Necessary for the Participant's care.

Consultation Services

Covered when the special skill and knowledge of a consulting physician is required for the diagnosis or treatment of an illness or Injury.

Staff consultations required by Hospital rules are excluded. Referrals, the transfer of a patient from one Physician to another for treatment, are not consultations under this Plan.

Second Medical Opinion

Covered services include a second medical opinion by a Network Physician with respect to any proposed surgical intervention or, when pre-certified by the Medical Claims Administrator, any medical care that is a covered service.

General Anesthesia Services

Covered when ordered by the attending physician and administered by another physician who customarily bills for such services, in connection with a covered procedure. To be payable, anesthesia must be given with other covered care.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded)

Anesthesia services administered by a certified registered nurse anesthetist (CRNA) are only covered when billed by the supervising Physician.

Autism Services

Your Plan includes coverage for the treatment of neurological deficit disorders, including autism. Your Plan also covers certain treatments associated with autism spectrum disorder (ASD) for

dependents through age 19. Coverage for ASD includes but is not limited to the following:

- Habilitative or rehabilitative services including Applied Behavior Analysis or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. To be eligible for coverage, Applied Behavioral Analysis shall be provided by a person professionally certified by a national board of behavior analysts.
- Counseling services provided by a licensed psychiatrist, licensed psychologist, professional counselor, or clinical social worker.
- Therapy services provided by a license or certified speech therapist, speech-language pathologist, occupational therapist, physical therapist, or marriage and family therapist, without regard to general limitations for physical, occupational and speech therapy.

Habilitative Physical, Occupational and Speech Therapy

Benefits are provided for physical, occupational, and speech therapy if the therapy is Medically Necessary and will result in a practical improvement in the level of functioning within a reasonable period of time. Benefits for habilitative physical, speech or occupational therapy are listed in the **Schedule of Benefits**. Such benefits are habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Chiropractic Services

Benefits are available for chiropractic treatments provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing,
manipulations, and treatment. Chiropractic benefits are listed in the **Schedule of Benefits**.

Benefits do not include the following:

- 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.
- Nutritional or dietary supplements, including vitamins.
- Cervical pillows.
- Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

Colorectal Cancer Examinations and Laboratory Tests

Covered Services include colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines for colorectal cancer screening. Benefits shall be provided for Participants who are 50 years of age or older and less than 50 years of age and at high risk for colorectal cancer according to the current colorectal cancer screening guidelines of the American Cancer Society. These services will be covered as a Preventive Care Service under the Plan (see below), unless they are diagnostic in nature.

Gene Therapy

Your Plan includes benefits for gene therapy services, when the Medical Claims Administrator approves the benefits in advance through Precertification. See "Getting Approval for Benefits" for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is an In-Network Provider for other services it may not be an approved Provider for

certain gene therapy services. Please call the Medical Claims Administrator to find out which providers are approved Providers. (When calling Member Services, ask for the Transplant Case Manager for further details.) Your Plan does not include benefits for the following gene therapy services:

- Services determined by the Medical Claims Administrator to be Experimental or Investigational,
- Services provided by a non-approved Provider or at a non-approved Facility,
- Services not approved in advance through Precertification.

Reproductive Health Services

Contraceptive Benefits

Prescription oral contraceptive drugs, injectable contraceptive drugs and patches are eligible for coverage. Benefits are also available for contraceptive devices including diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.

Infertility

Important Note: Although this Plan provides limited coverage of certain services related to Infertility, it does not include comprehensive coverage for Infertility treatment. Benefits are not available for
assisted reproductive technologies (ART) or the associated diagnostic testing and Prescription Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT). See Limitations and Exclusions.

Benefits are available for diagnostic tests used to determine the cause of Infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits are also available for services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). However, benefits are not available for Infertility treatments such as artificial insemination and in-vitro fertilization.

Maternity Care

Benefits are provided for In-Network Maternity Care and are not subject to the Copayment as stated in the **Schedule of Benefits**. If you choose an Out-of-Network provider, benefits are subject to the deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

Maternity benefits are provided for Employees and Dependents.

Routine newborn nursery care is part of the mother's maternity benefits. Routine newborn pediatrician visits in the Hospital are covered. Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See **"Special Enrollment – New Dependents"** to add coverage for a newborn.) A baby born to a dependent child is not eligible for coverage except for routine nursery care as mentioned above.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to the Medical Claims Administrator. Covered Services will include the obstetrical care given by that provider through the end of the pregnancy and the immediate post-partum period.

Under federal law, the Plan may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, the Plan may not require a Provider to get authorization before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Skilled Nursing Facility Care

Precertification is required for coverage of skilled nursing facility care. Benefits are provided for semiprivate room charges in a Skilled Nursing Facility, for up to the number of days of care per calendar year as outlined in the **Schedule of Benefits**. This care must be ordered by the attending Physician and benefits are available only if the patient requires a physician's continuous care and 24-hour-a-day nursing care.

Preventive Care Services

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 an In-Network Provider. Contact Customer Service if you are unsure whether a service is a Preventive Care service.

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 ACA-recommended preventive services.

Covered Preventive Care Services fall under the following broad groups:
1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include 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 listed in the guidelines supported by the Health Resources and Services Administration;

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

a. Women's contraceptives, sterilization treatments, and counseling. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered.
b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.
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 counseling for

tobacco cessation and nicotine replacement medication covered under the pharmacy benefit.

Please note that certain age and gender and quantity limitations apply. You may call the Medical Claims Administrator's Member Services at the number on your Identification Card for more details about these services or view the federal government's web sites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html. For details about tobacco cessation medication, call the Pharmacy Claims Administrator.

Covered Preventive Care Services also include the following services, some of which may be required by law to be covered:

- Lead poisoning screening for children.
- Routine mammograms (usually every one to two years for women over 40)
- Appropriate and necessary childhood immunizations that meet the standards approved by the U.S. public health service for such biological products against at least all of the following:
  - Diphtheria,
  - Pertussis,
  - Tetanus,
  - Polio,
  - Measles,
  - Mumps,
  - Rubella,
  - Hemophilus influenza b (Hib),
  - Hepatitis B,
  - Varicella.

  (Additional immunizations will be covered per federal law, as indicated earlier in this section.)
- Routine colorectal cancer examination and related laboratory tests.
- Chlamydia screening.
- Ovarian surveillance testing.
- Pap smear.
- Prostate screening.

Office Visits and Physician Services

Covered Services include the following:

Office Visits for medical care and consultations (including second surgical opinion) to examine, diagnose, and treat an illness or Injury.

Online Visits

Covered Services include a medical 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.

Home Visits for medical care and consultations to examine, diagnose, and treat an illness or Injury. Please note that a Physician visit in the home is not considered part of the "Home Health Care" benefit.

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

Walk-In Doctor's Office for services limited to routine primary care and the treatment of common illnesses for adults and children. A Walk-In Doctor's Office is a Physician practice that treats patients without requiring that they be existing patients or that they have an appointment.

Home Health Care Services

Home Health Care provides a program for the Participant's care and treatment in the home. The coverage limit is listed in the **Schedule of Benefits**. A visit consists of up to 4 hours of care. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending physician.

Some special conditions apply:

- The physician's statement and recommended program should be submitted for prior approval to the Pre-Certification Unit of the Medical Claims Administrator.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis.
- A patient must be essentially confined at home.

Covered Home Health Services:

- Visits by an R.N. or L.P.N. Benefits cannot be provided for services if the nurse is related to the patient.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the patient to understand the emotional, social, and environmental factors resulting from or affecting the patient's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an R.N.
- Nutritional guidance when Medically Necessary.
- Administration of prescribed drugs.
- Oxygen and its administration.

Exclusions: Home Health Care Benefits shall not be provided for:

- Food, housing, homemaker services, sitters, home-delivered meals.
- Home Health Care services, which are not Medically Necessary or are of a non-skilled level of care.
- Services and/or supplies which are not included in the Home Health Care plan as described.
- Services of a person who ordinarily resides in the patient's home or is a member of the family of either the patient or patient's spouse.
- Any services for any period during which the patient is not under the continuing care of a physician.
- Convalescent or Custodial Care where the patient has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the patient.
- Any services or supplies not specifically listed as Covered Services.

- Routine care and/or examination of a newborn child.
- Dietitian services.
- Maintenance therapy.
- Dialysis treatment.
- Purchase or rental of dialysis equipment.
- Private duty nursing care.

Hospice Care Program

Hospice benefits cover Inpatient and outpatient services for patients certified by a physician as terminally ill with a life expectancy of six months or less. A "Hospice" is a facility that provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. A "Hospice Care Program" is a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Participant and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed by the appropriate state agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

The Plan provides benefits for Inpatient and outpatient hospice care as stated in the **Summary of Benefits**.

The hospice treatment program must:

- Be recognized as an approved hospice program by the Medical Claims Administrator;
- Include support services to help covered family members deal with the patient's death; and
- Be directed by a physician and coordinated by an R.N. with a treatment plan that:
  - provides an organized system of home care;
  - uses a hospice team; and
  - has around-the-clock care available.

To qualify for hospice care, the attending physician must certify that the patient is not expected to live more than six months. Also, the physician must design and recommend a hospice-care program. The physician's statement and recommended program should be submitted for prior approval to the Pre- Certification Unit of the Claims Administrator.

Hospice Care - Covered Services

The program covers services and supplies ordered by the physician who directs the hospice-care program and which are provided to reduce pain or distress:

- Routine home care. The hospice will be paid the routine home-care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care.
- Continuous home care. The hospice will be paid for continuous home care when, in order to maintain the terminally ill patient at home, nursing care is necessary on a continuous basis during crisis periods. Care would have to be provided for a period of at least eight hours before the continuous home-care rate would be paid. The continuous home-care rate is divided by 24 hours to arrive at an hourly rate. For every hour or portion of continuous care furnished, the hourly rate will be reimbursed to the hospice until the full rate is reimbursed for 24 hours of continuous care furnished in a day. The

continuous home-care rate is intended only for periods of crisis where predominantly skilled nursing care is needed on a continuous basis in the management of the patient's acute medical symptoms; and only as necessary to maintain the patient at home.

- Inpatient Respite Care. The hospice will be paid at the Inpatient respite-care rate for each day the beneficiary is in an approved facility. The Inpatient respite-care rate will apply specifically to situations where the patient's family members or other persons caring for the patient need a short period of relief. The Inpatient respite-care rate will be paid for the date of admission and for each subsequent Inpatient day, except the day on which the patient is discharged. (The hospice will be paid at the appropriate home-care rate for the discharge day.) Inpatient Respite Care may be provided only on an intermittent, non-routine, and occasional basis and may not be reimbursed for more than five days at a time.
- General Inpatient Care. Normal Hospital benefits are paid for short-term Inpatient care for pain control or management of acute and severe clinical problems that cannot be handled in other settings. The Hospital rather than the hospice will be reimbursed for services furnished when the beneficiary is in an approved Inpatient facility for the performance of complicated procedures. For example, payment at the Inpatient rate will be made during situations when the patient's condition is such that it is no longer possible to maintain the patient at home. None of the other fixed payment rates will be applicable for a day on which the patient receives Inpatient care.

Services and supplies must be provided within 180 days after the date the person enters the program.

General Inpatient care for acute conditions is not covered as hospice care under the Plan. If the patient is readmitted to a Hospital for an unrelated condition, the remaining hospice benefits will be suspended until the patient re-enters the hospice program.

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or Injury (not for screenings or preventive care)
- Tests ordered prior to a surgical procedure or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)

- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services is subject to change as medical technologies change.

Individual Case Management Program

The individual case management program is designed to ensure and provide payment of benefits to eligible Participants who, with their attending Physician, agree to treatment under an alternative benefit plan intended to provide quality health care under lower cost alternatives. Such benefits will be determined on a case-by-case basis, and payment will be made only as agreed to under a written alternative benefit plan for each Plan participant developed by the Medical Claims Administrator.

The program includes:

- the identification of potential program participants through active case finding and referral mechanisms;
- eligibility screening;
- reparation of alternative benefit plans;
- subsequent to the approval of the parties, transfer to alternative treatment settings in which quality care will be provided.

Individual Case Management Program - Eligibility

A Participant receiving benefits under an alternative benefit plan may, at any time, elect to discontinue the plan and revert to regular Plan benefits.

The Medical Claims Administrator is responsible for determining eligibility for cases to be included in the program.

The Participant—or legal guardian or family member, if applicable—and the attending Physician must consent to explore with the Medical Claims Administrator the possibilities of transfer to an alternative treatment setting and, prior to implementation, agree to the alternative benefit plan.

Individual Case Management Program - Benefits

Benefits will be determined on a case-specific basis, depending on the plan of treatment, and may include Covered Services under the applicable Plan. Services will be covered and payable as long as the treatment is required as outlined in the alternative benefit plan, and is less expensive than the original treatment plan which otherwise would have been followed. The Medical Claims Administrator will determine the maximum approved payments allowable under the program.

Benefits under the program are furnished as an alternative to other Plan benefits and are limited to the following:

- services, equipment and supplies which are approved as Medically Necessary for the treatment and care of the Participant;
- non-structural modifications to the home, which are required to meet minimum standards for safe operation of equipment; and
- when necessary for the long term care of the Participant in the home-setting, Respite Care to relieve family members or other persons caring for the Participant at home. (The Respite Care benefit can be credited at a rate of 24 hours for every month of care rendered in the home setting, and may be reimbursed for up to 6 consecutive days at a time. The Medical Claims Administrator may approve on an exception basis up to 5 days per month of Respite Care when medical review of the case indicates that such action is appropriate).

The Participant must obtain pre-certification regarding the treatment plan and proposed setting to be utilized during the Respite Care period.

Potential cases include, but are not limited to:

- spinal cord Injury;
- severe head trauma/coma;
- respiratory dependence;
- degenerative muscular/neurological disorders;
- long term IV antibiotics;
- premature birth;
- burns;
- cardiovascular accident;
- cancer;
- accidents;
- terminal illnesses;
- other cases at the Medical Claim Administrator's discretion.

Individual Case Management Program - Covered Services

Services covered under individual case management will be determined by the Medical Claims Administrator on a case-by- case basis. Benefits may be provided for the rehabilitation of a Participant on an outpatient, or out- of-Hospital basis, as long as they are Medically Necessary, support the plan of treatment, and ensure quality of care.

The program may provide or coordinate any of the types of Covered Services provided pursuant to this booklet.

At its sole discretion, in the context of an individual case management program, the Medical Claims Administrator may also provide or arrange for alternative services or extra-contractual benefits which are either (i) excluded by this booklet; (ii) neither excluded nor defined as Covered Services under this booklet; or (iii) exceeding the maximum for any Covered Service under this booklet.

- Utilization: Benefits will be provided only when and for as long as the Medical Claims Administrator deems them Medically Necessary. The approved alternative benefit plan of treatment will establish which benefits will be provided and for how long, and shall be

subject to pre-certification and continuing review for Medical Necessity as set forth in such plan for treatment. The total benefits paid under this program will not exceed those which the Participant would otherwise have received in the absence of individual case management benefits.

- Exclusions: Rehabilitation or Custodial Care for chronic (recurring) conditions that do not, in the Medical Claim Administrator's sole discretion, significantly improve in an observable way within a reasonable period of time will not be a covered benefit under the individual case management program.

Definitions

- Case Manager: The person designated by the Medical Claims Administrator to manage and coordinate the Participant's medical benefits under the individual case management program.
- Provider: A Provider may be any facility or practitioner licensed or certified to give services or supplies consistent with the Plan of Treatment and approved by the Medical Claims Administrator.

Termination of Individual Case Management

Services in the alternative benefit plan approved by the Claims Administrator under individual case management will cease to be Covered Services under this Plan when extra-contractual benefits or alternative services are no longer Medically Necessary, as determined by the Plan due to a change in the patient's condition.

Organ/Tissue/Bone Marrow Transplant

Covered Services include certain services and supplies not otherwise excluded in this booklet and rendered in association with a Covered Transplant, including pre-transplant procedures such as organ harvesting (Donor, Costs) post-operative care (including antirejection drug treatment under the Pharmacy benefits of the Plan) and transplant related chemotherapy for cancer limited as follows. A transplant means a procedure or series of procedures by which an organ or tissue is either:

- removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient); or
- removed from and replaced in the same person's body (called a self-donor).

A "Covered transplant" means a Medically Necessary transplant of one of the following organs or tissues only and no others:

- Human organ or tissue transplants for cornea, lung, heart or heart/lung, liver, kidney, pancreas or kidney and pancreas when transplanted together in the same operative session.
- Autologous (self-donor) bone marrow transplants with high-dose chemotherapy is considered eligible for coverage on a prior approval basis, but **only** if required in the treatment of:
- Non-Hodgkin's lymphoma, intermediate or high grade Stage III or IVB;
- Hodgkin's disease (lymphoma), Stages IIIA, IIIB, IVA, or IVB;
- Neuroblastoma, Stage III or Stage IV;
- Acute lymphocytic or nonlymphocytic leukemia patients in first or subsequent remission, who are at high risk for relapse and who do not have an HLA-compatible donor available for allogenic bone marrow support;

- Germ cell tumors (e.g., testicular, mediastinal, retroperitoneal, ovarian) that are refractory to standard dose chemotherapy, with FDA-approved platinum compounds;
- Metastatic breast cancer that (a) has not been previously treated with systemic therapy, (b) is currently responsive to primary systemic therapy, or (c) has relapsed following response to first-line treatment;
- Newly diagnosed or responsive multiple myeloma, previously untreated disease, those in a complete or partial remission, or those in a responsive relapse; and
- Homogenic/allogenic (other donor) or syngeneic hematopoietic stem cells whether harvested from bone marrow peripheral blood or from any other source, but only if required in the treatment of:
    - aplastic anemia;
    - acute leukemia;
    - severe combined immunodeficiency **exclusive** of acquired immune deficiency syndrome (AIDS);
    - infantile malignant osteoporosis;
    - chronic myelogenous leukemia;
    - lymphoma (Wiscott-Aldrich syndrome);
    - lysosomal storage disorder;
    - myelodysplastic syndrome.

Definitions:

- "Donor Costs" means all costs, direct and indirect (including administration costs), incurred in connection with:
    - medical services required to remove the organ or tissue from either the donor's or the self- donor's body;
    - preserving it; and
    - transporting it to the site where the transplant is performed.
- In treatment of cancer, the term "transplant" includes any chemotherapy and related courses of treatment, which the transplant supports.
- For purposes of this benefit, the term "transplant" does not include transplant of blood or blood derivatives (except hematopoietic stem cells), which will be considered as non-transplant related under the terms of the Plan.
- "Facility Transplant" means all Medically Necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and antirejection drugs.
- "Professional Provider Transplant Services" means all Medically Necessary services and supplies provided by a professional provider in connection with a covered transplant except Donor Costs and antirejection drugs.

Benefits for Antirejection Drugs
For antirejection drugs following the covered transplant, the Plan will pay according to the Pharmacy benefits under the Plan.

Transplant Transportation and Lodging

The Plan will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. Assistance with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Participant receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to the Medical Claims Administrator when claims are filed. Call the Medical Claims Administrator for complete information.

For lodging and ground transportation benefits, the Plan will cover costs 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 Medical Claims 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,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation.
- Meals.

Transplant Pre-certification Requirement

All transplant procedures must be pre-certified for type of transplant and be Medically Necessary. To pre-certify, call the Medical Claims Administrator office using the telephone number on your Identification Card.

The pre-certification requirements are a part of the benefit administration of the Plan and are not a treatment recommendation. The actual course of medical treatment the Participant chooses remains strictly a matter between the Participant and his or her Physician.

Your Physician must submit a complete medical history, including current diagnosis and name of the surgeon who will perform the transplant. The surgery must be performed at a recognized transplant center. The donor, donor recipient and the transplant surgery must meet required medical selection criteria as defined by the Claims Administrator.

If the transplant involves a living donor, benefits are as follows:

- If a Participant receives a transplant and the donor is also covered under this Plan, payment for the Participant and the donor will be made under each individual's coverage.

- If the donor is not covered under this Plan, payment for the Participant and the donor will be made under this Plan, but will be limited by any payment which might be made under any other Hospitalization coverage plan.
- If the Participant is the donor and the recipient is not covered under this Plan, payment for the Participant will be made under this Plan limited by any payment, which might be made by the recipient's Hospitalization coverage with another company. No payment will be made under this Plan for the recipient.

Approved Clinical Trials

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

Benefits are limited to the following trials:

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

The Plan may require you to use an In-Network Provider to maximize your benefits.

When a requested medical service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. However, Experimental/investigational drugs are excluded even if they are part of an approved Clinical Trial, except as stated in the definition of experimental/investigational under the Pharmacy benefits section of this booklet.

Exclusions

The Plan is not required to provide benefits for the following services, and reserves the right to exclude any or all of the following services:

- The Investigational item, device, or service, itself;
- Items and services given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

All requests for clinical trials services that are not part of approved clinical trials will be reviewed according to the Medical Claims Administrators' clinical coverage guidelines and related policies and procedures.

Telemedicine

Your coverage also includes Telemedicine Services provided by a duly licensed Physician or healthcare Provider by means of audio, video, or data communications (to include secured electronic mail). The use of standard telephone, facsimile transmissions, unsecured electronic mail, or a combination thereof does not constitute Telemedicine Service and is not a covered benefit. Neither a telephone conversation nor an electronic mail message between a healthcare practitioner and a patient is telemedicine. The use of Telemedicine may substitute for a face-to-face "hands on" encounter for consultation.

To be eligible for payment, interactive audio and video telecommunications must be used, permitting real-time communications between the distant Physician or Provider and the Participant / patient. As a condition of payment, the patient (Participant) must be present and participating.

Telehealth Services

A health care service, other than a telemedicine service, delivered by a licensed or certified health professional, acting within the scope of the healthcare professional's license or certification, who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile.

Other Covered Services:

- Use of Operating and Treatment Rooms and Equipment Diagnostic X-ray and Laboratory Procedures Chemotherapy and Radioisotope, Radiation
- Nuclear Medicine Therapy
- Oxygen, Blood and Components, and Administration
- Dressings, Splints, Casts
- Pacemakers and Electrodes
- Diabetic supplies used for testing blood and urine specimens at home
- Autism Services - the Plan includes coverage for the treatment of neurological deficit disorders.

  Please see Section 7 "Limitations and Exclusions" for Non-Covered Services.

8. Mental Health, Alcoholism and Chemical Dependency Treatment

Benefits for Inpatient and outpatient charges for treatment of Mental Health Disorders, Alcoholism, and Chemical Dependency are subject to the deductible and percentage payable provisions as shown in the **Schedule of Benefits.** For all treatment other than outpatient office visits, pre-certification is required.

Mental Health Services

Benefits are provided for the following:

- Psychiatric services;
- Inpatient or outpatient diagnosis and treatment of Mental Health Disorders;

Outpatient services must be provided by a physician or Hospital. Inpatient services must be prescribed by a Physician and received in a Hospital or residential treatment facility.

Covered services include:

- diagnostic or evaluative procedures;
- therapeutic procedures;
- consultative, diagnostic or therapeutic visits, including online visits with a Physician 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 Physicians outside the online care panel, benefit precertification, or Physician to Physician discussions;
- drug management;
- electroconvulsive therapy;
- other psychiatric therapies, services or procedures. Inpatient mental health services: daily room and board;
- miscellaneous services and supplies, other than room and board, for any day room and board benefits are payable;
- physician's Eligible Charges for treatment of a mental disorder;
- physician Eligible Charges for psychiatric services; and
- partial confinement.

Alcoholism and Chemical Dependency Treatment Services

Treatment must be prescribed by a physician and received in or provided by one of the following:

- A Hospital;
- An Alcoholism treatment facility;
- A Chemical Dependency treatment facility;
- A Physician.

Eligible Charges include:

- Inpatient room and board charges;
- Inpatient and outpatient charges for Covered Services and supplies;
- Physician charges for Inpatient or outpatient treatment.

Mental Health Care or Substance Abuse Treatment information may be obtained by calling 1-800-292-2879.

9. Medical Benefit Limitations and Exclusions

This Plan does not provide medical benefits for:

- Care, supplies, or equipment not Medically Necessary, as determined by the Plan, for the treatment of an Injury or illness.
- Services rendered or supplies provided before coverage begins, (i.e., before a Participant's effective date of coverage), or after coverage ends. Such services and supplies shall include, but not be limited to Inpatient Hospital admissions which begin before a Participant's Effective Date, continue after the Participant's Effective Date, and are covered by a prior carrier.
- Any services rendered or supplies provided while you are confined in an Ineligible Hospital.
- Hospital Services Duplicative Bills - Services rendered by Hospital resident Doctors or interns that are duplicative in nature. This includes separately billed, duplicate charges for services rendered by employees of Hospitals, labs or other institutions.
- Any services rendered or supplies provided while you are a patient or receive services at or from an Ineligible Provider.
- Any portion of a provider's fee or charge which is ordinarily due from a Participant, but which has been waived. If a provider routinely waives (does not require the Participant to pay) a Deductible or Out-of-Pocket amount, the Claims Administrator will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law.
- Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.
- Any item, service, supply or care not specifically listed as a Covered Service in this booklet.
- Care given by a medical department or clinic run by your Employer.
- Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
- Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
- Skilled Nursing Facility – services provided by Skilled Nursing Facility, except as specifically stated as Covered Services.

- Care of corns, bunions (except capsular or related surgery), callouses, toenail (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet.
- Daily room charges while the Plan is paying for an Intensive Care, cardiac care, or other special care unit.
- Vision care services and supplies, including, but not limited to eyeglasses, contact lenses, and related examinations and services; eye refractions, analysis of vision or the testing of its acuity, service or devices to correct vision or for advice on such service. This exclusion does not apply to recommended vision screenings for children that are covered as a Preventive Service under the Plan.
- Hearing aids, hearing devices and related or routine examinations and services, including but not limited to exams to fit hearing aids including bone anchored hearing aids. This exclusion does not apply to cochlear implants or to recommended hearing screenings for children that are covered as a Preventive Service under the Plan.
- Aids for non-verbal communication devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by the Medical Claims Administrator.
- Autopsies and post-mortem testing.
- Treatment (outside U.S.) – Non-emergency treatment of chronic illnesses received outside the United States performed without authorization.
- Waived Fees- Any portion of a provider's fee or charges which is ordinarily due from a participant but which has been waived. If a provider routinely waives (does not require the participant to pay a deductible or out of pocket amount), the Medical Claims Administrator will calculate the actual provider's fee or charges by reducing the fee or charges by the amount waived.
- Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats, which are not called for by known symptoms, illness or Injury except those which may be specifically listed as covered in this booklet.
- The following items related to Durable Medical Equipment
    - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
    - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
    - Non-Medically Necessary enhancements to standard equipment and devices.
    - Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. 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.
    - Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies,

dressings, appliances or devices that are not specifically listed as covered in this Booklet.

- Air conditioners, humidifiers, dehumidifiers, or purifiers;
- Arch supports and orthopedic or corrective shoes;
- Heating pads, hot water bottles, home enema equipment, or rubber gloves;
- Sterile water;
- Rental or purchase of equipment if you are in a facility which provides such equipment;
- Electric stair chairs or elevator chairs;
- Physical fitness, exercise, or ultraviolet/tanning equipment;
- Residential structural modification to facilitate the use of equipment;
- Other items of equipment which do not meet the listed criteria.

- Custodial Care, domiciliary care, rest cures, or travel expenses (except those travel expenses expressly stated as covered for transplant services) even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain, except as specifically stated as Covered Services. Transportation to another area for medical care is excluded except when Medically Necessary for you to be moved by ambulance from one Hospital to another Hospital. Ambulance transportation from the Hospital to the home is not covered.
- Services provided by a rest home, a home for the aged, a nursing home or any similar facility.
- Services provided by a Skilled Nursing Facility, except as specifically stated as Covered Services.
- Care, supplies, or equipment not Medically Necessary for the treatment of an Injury or illness. Non- covered supplies are inclusive of but not limited to band-aids, tape, non-sterile gloves, thermometers, heating pads and bed boards. Other non-covered items include household supplies, including but not limited to, the purchase or rental of exercise cycles, water purifiers, hypo- allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, exercise and massage equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a Participant's house or place of business, and adjustments made to vehicles.
- Cosmetic Surgery/Beautification Procedures – Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, unless treatment relating to such consequences is Medically Necessary. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties.
- Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary, are not covered. This exclusion does not apply to surgery to restore function if any area of the body has been altered by disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This exclusion does not apply to surgery to correct the results of Injuries when performed within two (2) years of the event causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

- The following criteria must be met to qualify for breast reduction surgery: The affected area must be more than 250 grams over the normative average. This exclusion does not apply to Breast Reconstructive Surgery. Please see the "Description of Benefits and Services" section of this booklet.
- Complications of non-covered procedures performed while the Participant is enrolled are not covered.
- Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions (except impacted teeth); endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy; or other dental procedures except those specifically listed as covered in this booklet.
- Care prescribed and supervised by someone other than a Physician unless expressly stated in this booklet.
- Except as may be provided in the "Description of Benefits and Services" section, any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription Drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding except when it's the sole means of nutrition. Food supplements. Weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature.
- Procedures to lower stomach capacity, limit food consumption, or reduce stomach size, including, but not limited to Roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries to lower stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), gastroplasty, (surgeries that reduce stomach size), gastric banding procedures, gastric balloons, jejunal bypasses, and wiring of the jaw.
- Sclerotherapy – Sclerotherapy of extremity veins.
- Except as expressly stated as covered in "Description of Benefits and Services" for transplants, transportation provided by other than a state licensed Professional Ambulance Service, and ambulance services other than in a medical emergency.
- Hair transplants, hair pieces or wigs (except when necessitated by disease), wig maintenance, or prescriptions or medications related to hair growth.
- Advice or consultation given by any form of telecommunication, except as expressly stated as a covered Online Visit or as covered in Section 4 (Telemedicine and Telehealth).
- Treatments, procedures, equipment, drugs, devices, or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated. An Experimental or Investigational service is not made eligible for coverage by the fact that other treatment is considered by a Participant's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life (see Section 13 for definition of "Experimental or Investigational" services).
- Clinical Trial Non-Covered Services - Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
- Services and supplies for which you have no legal obligation to pay, or for which no charge has been made or would be made if you had no health insurance coverage.

- Charges for failure to keep a scheduled visit or for completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.
- Services rendered by a provider who is a close relative or member of your household. Close relative means wife or husband, parent, child, brother or sister, by blood, marriage or adoption.
- Services for outpatient therapy or rehabilitation other than those specifically listed in this booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, cognitive therapy, electromagnetic therapy, vision perception training (orthoptics), salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne, services and supplies for smoking cessation programs and treatment of nicotine addiction, and carbon dioxide. This exclusion does not apply to counseling for tobacco use that is covered as a Preventive Service under the Plan.
- Radial keratotomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.
- Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which you as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
- Services for which benefits are payable under Medicare Parts A or B. See "Coordination of Benefits with Medicare" for more information.
- Expenses in excess of the Maximum Allowed Amount.
- Services related to or performed in conjunction with artificial insemination, gamete intrafallopian transfer (GIFT) procedure, and in-vitro fertilization, reverse sterilization or a combination thereof; or other Infertility or assisted reproductive technology services designed primarily for the purpose of conception.
- Biofeedback, recreational, educational or sleep therapy or other forms of self-care or self-help training and any related diagnostic testing.
- Personal comfort items such as those that are furnished primarily for your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
- Educational services or supplies for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.
- Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Participant is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
    - the treatment is for maintenance therapy; or
    - the Participant has no restorative potential; or
    - the treatment is for congenital learning, communication training, educational training or vocational training.

- Injuries received while engaged in the commission or attempted commission of an illegal activity, including misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) if the injury solely resulted from your medical condition (including both physical and mental health conditions).
- Biomicroscopy, field charting or aniseikonic investigation.
- Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training.
- The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
    - Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
    - Transportation, travel or lodging expenses for non-donor family members;
    - Donation related services or supplies, including search, associated with organ acquisition and procurement;
    - Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered;
    - Any transplant not specifically listed as covered.
- Alternative/Complementary Medicine Services or supplies for alternative or complementary medicine. This includes, but is not limited to:
    - Acupuncture,
    - Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body.
    - Holistic medicine,
    - Homeopathic medicine,
    - Hypnosis,
    - Aroma therapy,
    - Massage and massage therapy,
    - Reiki therapy,
    - Herbal, vitamin or dietary products or therapies,
    - Naturopathy,
    - Thermography,
    - Orthomolecular therapy,
    - Contact reflex analysis,
    - Bioenergial synchronization technique (BEST),
    - Iridology-study of the iris,
    - Auditory integration therapy (AIT),
    - Colonic irrigation,

  - Magnetic innervation therapy,
  - Electromagnetic therapy,
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
- Court-ordered services, or those required by court order as a condition of parole or probation.
- Hypnotherapy.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Specific medical reports, including those not directly related to treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
- Thermograms and thermography.
- Treatment of nicotine dependence. This exclusion does not apply to counseling for tobacco use. Note: See the Pharmacy Benefits Section for information about coverage of nicotine replacement therapy.
- Health or fitness 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.
- Personal Care, Convenience and Mobile/Wearable Devices
  - Items for personal comfort, convenience, protective, or cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs;
  - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads);
  - Home workout or therapy equipment, including treadmills and home gyms;
  - Pools, whirlpools, spas, or hydrotherapy equipment;
  - Hypo-allergenic pillows, mattresses, or waterbeds; or
  - Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
  - Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.
- Cryopreservation Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
- Dental Devices for Snoring - Oral appliances for snoring.
- Growth Treatment, Services, and Supplies - Any treatment, device, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

- Hyperhidrosis Treatment Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Residential Accommodations - Residential Accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center. This Exclusion includes procedures, equipment, service, supplies or charges for the following:
    - Domiciliary 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.
    - 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, or experiential or outdoor education program, even if psychotherapy is included.
- Wilderness or other outdoor camps and/or programs.

10. Medical Benefit Claims and Appeals Procedures

10.A Claim Payments

The Claims Administrator may make benefit payments directly to In-Network Providers for Covered Services. If you use an Out-of-Network Provider, however, the Claims Administrator may make benefit payments to you or the Out-of-Network Provider, at the Claims Administrator's discretion. A Member may assign benefits to a provider who is not an In-Network provider but it is not required. If a Member does
not assign benefits to an Out-of-Network Provider, any benefit payment will be sent to the Member.

10.B Claim Submission

- In-Network: If you receive care from an In-Network Provider, the In-Network Provider will file claims for you.
- Out-of-Network: If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Physicians and other providers will still submit your claim for you, although they are not required to do so. If you submit the claim, use a claim form as described later in this section. You may obtain these from www.gacities.com/LHForms or from the Claims Administrator. Claim forms should include your name, Plan and Group numbers exactly as they appear on your Identification Card. Attach all bills to the claim form and file directly with the Medical Claims Administrator. Be sure to keep a photocopy of all forms and bills for your records. Save all bills and statements related to your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies. To receive benefits, a properly completed claim form with any necessary reports and records must be filed within 90 days of the date of service.
- Out-of-State and Out-of-Country: Please contact the Customer Service number on your Identification Card for information about how to file claims when you obtain medical services out of the state of Georgia or out of the United States.

10.C Claim Appeals Procedures

The Claims Administrator has discretion to interpret the terms of the Plan that pertain to payment of medical claims, and is solely responsible for administering all medical claims and making all decisions related to medical claims.

Appeal of Denial to Claims Administrator

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:

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

The procedure the Claims 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 Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them;
- 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; and
- 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.

For claims involving urgent/concurrent care:

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

Access to Records

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant"

means that the document, record, or other information:

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

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive a denial on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale. You will have a reasonable opportunity to respond to any new information provided to you prior to the date on which a final decision on appeal is required.

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

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

- For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Administrator at [the number shown on your identification card] and provide at least the following information:
    - the identity of the claimant;
    - the date(s) of the medical service;
    - the specific medical condition or symptom;
    - the provider's name;
    - the service or supply for which approval of benefits was sought; and
    - any reasons why the appeal should be processed on a more expedited basis.
- All other requests for Appeals (Grievances), should be submitted in writing by the Participant or the Participant's authorized representative, except where the acceptance of oral Appeals (Grievances) is otherwise required by the nature of the appeal (e.g., urgent care).

In State Appeals: You or your authorized representative must submit a request for review of denials of medical benefits to:

Anthem, Inc.
P.O Box 9907
Columbus, GA 31908

Out of State Appeals: Providers must file appeals with the same Anthem plan to which they submitted the original claim.

How Your Appeal will be Decided

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

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

In order to decide your appeal, the Claims Administrator may need information from the provider of the services and other insurance programs that may provide benefits related to the claim. As a Participant, you agree to authorize the Physician, Hospital, or other provider, or any other health plan or insurance program that provides benefits to you to release necessary information.

The Claims Administrator may use this information for any purpose necessary and appropriate for claims administration or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For information about how your information is used and protected by those who administer the Plan, see the Notice of Privacy Practices for GMEBS Health and Dental Plans, which is posted at www.gacities.com/LHForms in the Annual Legal Notices.

Timing of Claim Administrator's Response

The Claims Administrator will review the claim and make payment or issue a denial notice based on the type of claim filed within the following time periods:

- Urgent/Concurrent Care Claims—within 72 hours after receipt of the claim. If your claim is incomplete, you will be notified within 24 hours after receipt of the incomplete claim of the specific information needed to complete the claim. You will then have 48 hours to provide the required information. The Claims Administrator will defer to the attending provider with respect to the decision as to whether a claim is an Urgent/Concurrent Care Claim.
- Pre-Service Claims—within 30 days after receipt of the claim (unless a one-time 15-day extension is necessary due to matters beyond the control of the Claims Administrator). The Claims Administrator will notify you of the extension and the date a decision is expected. If an extension is necessary because you did not submit sufficient information to decide the claim, the notice will describe what's missing and you will have 45 days to provide the required information.

- Post-Service Claims—within 60 days after receipt of the claim (unless a one-time 15-day extension is necessary due to matters beyond the control of the Claims Administrator). The Claims Administrator will notify you of the extension and the date a decision is expected. If an extension is necessary because you did not submit sufficient information to decide the claim, the notice will describe what's missing and you will have 45 days to provide the required information.

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 (Grievances)

If you are dissatisfied with the Claim Administrator'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 (Grievances) 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.

Requesting an 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 Claims Administrator within four (4) months of the notice of your final internal adverse determination.

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

- For pre-service claims involving urgent/concurrent care, you may proceed with an expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the Claims Administrator's internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an expedited External Review, you or your authorized representative must contact the Claims Administrator at the number shown on your Identification Card and provide at least the following information:
    - the identity of the claimant;
    - the date(s) of the medical service;
    - the specific medical condition or symptom;
    - the provider's name;
    - the service or supply for which approval of benefits was sought; and
    - any reasons why the appeal should be processed on a more expedited basis.

- All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to the same address as set forth under "Appeals (Grievances)" above.

External Review by Independent Review Organization (IRO)

Upon determination that the claim is eligible for external review, the Claims Administrator will assign your claim to an independent review organization (IRO) that will conduct the external review. Upon assignment, the IRO will:

- Timely notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO additional information within 10 business days following the date of receipt of the notice that the IRO must consider when conducting the external review. The IRO is not required to but may accept and consider additional information submitted after 10 business days.
- Review all documents and any information considered in making a final Denial received by the Claims Administrator. The Claims Administrator will provide the IRO with such documents and information within 5 business days after the date of assignment of the IRO. Failure by the Claims Administrator to timely provide the documents and information will not delay the conduct of the external review. If the Claims Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the final Denial. In such case, the IRO will notify you and the Claims Administrator of its decision within 1 business day.
- Forward any information submitted by you to the Claims Administrator within 1 business day of receipt. Upon receipt of any such information, the Claims Administrator may reconsider its final Denial that is the subject of the external review. Reconsideration by the Claims Administrator must not delay the external review. The external review may be terminated as a result of reconsideration only if the Claims Administrator decides to reverse its final Denial and provide coverage or payment. In such case, the Claims Administrator must provide written notice of its decision to you and the IRO within 1 business day and the IRO will then terminate the external review.
- Review all information and documents timely received under a de novo standard. The IRO will not be bound by any decisions or conclusions reached during the Claims Administrator's claims process.
- In addition to the information and documents provided, the IRO, to the extent the information and documents are available and the IRO considers them appropriate, will further consider the following in reaching a decision: (i) your medical records, (ii) the attending Health Care Professional's recommendation; (iii) reports from appropriate Health Care Professionals and other documents submitted by the Claims Administrator, you, or your physician; (iv) the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan unless the terms are inconsistent with applicable law; (v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (vi) any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and (vii) the opinion of the IRO's clinical reviewer after considering the information described in this paragraph to the extent the information or documents are available and the clinical reviewer considers it appropriate.

Notice of External Review Decision

The external review decision will be rendered within the following time periods:

- Urgent/Concurrent Care Claims— within 72 hours after the IRO receives the request for expedited external review.
- All other Claims— within 45 days after the IRO receives the request for external review.

The IRO's notice will contain the following information:

- a general description of the reason for the request for external review, including information sufficient to identify the claim;
- the date the IRO received the assignment to conduct external review and the date of the final external review decision;
- references to the evidence or documentation, including specific coverage provisions and evidence- based standards, considered in reaching the decision;
- a discussion of the principal reason or reasons for the decision;
- a statement that the determination is binding except to the extent other remedies may be available under State or Federal law to the Plan or to the claimant; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Federal law.

If the IRO reverses the final denial of the Claims Administrator, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Maintenance of Records

All IROs that contract with the Claims Administrator to conduct external review will maintain records of all claims and notices associated with an external review for 6 years. The IROs will make such records available for examination by the claimant, the Claims Administrator, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

No Requirement to Initiate External Review

You are not required to initiate an external review 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 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 Claim Administrator's final decision on the claim or other request for benefits. If the Claims Administrator decides an appeal is untimely, the Claim Administrator's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust this Plan's internal appeals procedure before filing a lawsuit or taking other legal action of any kind against the Plan.

Unless the exception in the following paragraph applies, if the Claims Administrator fails to strictly adhere to all the requirements with respect to your claim under the internal claims and appeals rules of this Section, you will be deemed to have exhausted the internal claims and appeals process with respect to such claim. Accordingly, you may initiate an external review of the claim, as outlined above. You are also entitled to pursue any available remedies under state law with respect to the claim.

Notwithstanding the previous paragraph, the internal claims and appeals process will not be deemed exhausted based on *de minimis* (or insignificant) violations that do not cause you, and are not likely to cause you, prejudice or harm, so long as the Claims Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Claims Administrator and that the violation occurred in the context of an ongoing, good faith exchange

of information between you and the Claims Administrator. This exception is not available if the violation is part of a pattern or practice of violations by the Claims Administrator. You may request a written explanation of the violation from the Claims Administrator, and the Claims Administrator will provide such explanation within 10 days, including a specific description of the basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If the IRO or a court rejects your request for immediate review due to deemed exhaustion on the basis that the Claims Administrator met the standards for the exception described in this paragraph, you will have the right to resubmit and pursue the internal appeal of the claim. In such case, within a reasonable time after the IRO or court rejects the claim for immediate review (not to exceed 10 days), the Claims Administrator will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re- filing the claim will begin to run upon your receipt of such notice.

Form and Manner of Notices

Notices provided pursuant to this Section with respect to internal claims and appeals and external reviews will be provided in a culturally and linguistically appropriate manner pursuant to U.S. Department of Health and Human Services regulations. Accordingly, with respect to an address in any United States county to which a notice is sent, if 10% or more of the population residing in the county is literate only in the same non-English language (the "applicable non-English language"), the Claims Administrator will: (i) provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language; (ii) provide notices sent under this Section in the applicable non-English language upon request; and (iii) include a statement in the English versions of all notices sent under this Section, prominently displayed in the applicable non- English language, clearly indicating how to access language services provided by the Plan.

Effect of Federal Guidance on this Section

Any information, processes, standards of review, or other elements that are required to be provided under this Section shall be provided or applied only if the Plan is required to do so under applicable legal requirements and the U.S. Department of Health and Human Services is currently enforcing such requirements. For these purposes, the Plan may rely fully on the U.S. Department of Health and Human Services Technical Guidance published on June 22, 2011, the U.S. Department of Labor 2011 amendment to the interim final regulations published on July 23, 2010, and any subsequent guidance.

Definitions Related to the Claims and Appeals Procedures

- "Denial" or "Denied" means a Denial, reduction, termination, or failure to provide or make payment for a benefit, including determinations based on eligibility or Utilization Review, or a failure to cover a benefit because it is determined to be experimental or not Medically Necessary. A denial also means a rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.
- "Pre-Service Claim" means any claim where receipt of such benefit is conditioned, in whole or in part, on approval of the benefit prior to obtaining medical care.
- "Post-Service Claim" means any medical claim that is not an Urgent/Concurrent Care claim or a Pre-Service Claim.
- "Urgent/Concurrent Care Claim" means any claim for medical care or treatment where the failure to make a determination quickly: (i) could seriously jeopardize your life or health or your ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without such care or treatment.

Plan's Right of Reimbursement

If the amount of the payment made by us is more than it should have paid under this provision, we may recover the excess from one or more of:

- the persons we have paid or for whom we have paid,
- insurance companies, or
- other organizations.

10.D Complaints about Medical Network Provider Service

If you have a complaint about care received from a provider, please call the appropriate Customer Service Call Center on your Identification Card (medical or pharmacy). Your complaint will be addressed in a timely manner.

If there is a conflict between the policies, procedures and timeframes in this section and the requirements of applicable law, the Claims Administrator will follow the requirements of applicable law.

11. Accessing Medical Benefits for Out-of-Area Care

Licensed Controlled Affiliate

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Anthem to use the Blue Cross and Blue Shield Service Marks in the state of Georgia. Anthem is not acting as the agent of the Association.

Accessing Care Out of Area

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 the Medical Claims Administrator 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") do not contract with the Host Blue. Explained below is how both kinds of Providers are paid.

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, the Claims Administrator will still fulfill our contractual obligations. However, 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 the Claims Administrator.

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 Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

D. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem 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, the Plan may use other pricing methods, such as billed charges or the pricing we 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.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield

Global Core Service 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 us 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 "Getting Approval for Benefits" section in this 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.

Care Received Outside the United States

You will receive Plan benefits for care and treatment received outside the United States. Plan provisions will apply; all non-emergency care must be pre-certified. Any care received must be a Covered Service. Please pay the provider of service at the time you receive treatment and obtain appropriate documentation of services received including bills, receipts, letters and medical narrative. This information should be submitted with your claim. All services will be subject to review for Medical Necessity. The Claims Administrator will reimburse you directly.

Payment will be based on the Maximum Allowed Amount assuming the Participant's legal residence. Assignments of benefits to foreign providers or facilities cannot be honored.

12. Medical Benefit Definitions

All words capitalized in this Medical Benefits Booklet and not defined elsewhere have the meanings set forth below.

Accidental Injury
Bodily Injury sustained by a Participant as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Participant receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

Application for Enrollment
The original and any subsequent forms completed and signed by the Employee seeking coverage.

Applied Behavior Analysis
The process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement of behavior.

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

Balance Billing
When a health care provider bills you for the difference between the provider's charge and the Maximum Allowed Amount.

Center of Excellence
An In-Network health care facility selected to give specific services to Participants based on their experience, outcomes, efficiency, and effectiveness. To be a Center of Excellence, the Provider must have a Center of Excellence Agreement with the Medical Claims Administrator.

Chemical Dependency (Substance Abuse)
The total psycho-physical state of mind that involves feelings of satisfaction and a drive to periodic or continuous administration of the chemical (drug) to produce pleasure or avoid discomfort.

Chemical Dependency Treatment Facility
An institution established to care for and treat Chemical Dependency, on either an Inpatient or Outpatient basis, under a prescribed treatment program. The institution must have diagnostic and therapeutic facilities for care and treatment provided by or under the supervision of a licensed Physician. The facility must be licensed, registered or approved by the by the appropriate authority of the State of Georgia, the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Medical Claims Administrator.

Coinsurance
Your share of the costs of a covered health care service, calculated as a percent of the Maximum Allowed Amount for the service. You pay coinsurance plus any deductibles you owe. Coinsurance may be capped by the Out-of-Pocket Limit. Compare to Copayment.

Congenital Defect
A condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Copayment
A fixed amount you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. Copayments may be collected by the provider of service or the Claims Administrator.

Covered Dependent
Any dependent in an Employee's family who meets all of the applicable dependent eligibility requirements in the Eligibility section of this booklet, who has enrolled in the Health Plan, and for whom all required premiums have been paid.

Covered Services
Health care services, supplies, or treatment described in this Benefit Booklet that are given to you by a health care provider that is not an Ineligible Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Benefit Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigative, excluded, or limited by this Benefit Booklet, or by any amendment or rider to this Benefit Booklet.
- Approved by the Claims Administrator before you get the service if prior authorization or pre-certification is required.

A charge for a Covered Service will only apply on the date the service, supply, or treatment was given to you.

The date for applying Deductible and other cost shares for an Inpatient stay is the date you enter the facility except as described in the "When Coverage Terminates and Continuation of Coverage" section.

Covered Services do not include services or supplies not described in the Provider records.

Custodial Care
Any type or care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Participant has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Participant's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Participant, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Claims Administrator, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Deductible
The portion of the Maximum Allowed Amount you must pay before the Plan pays benefits. It usually is applied on a calendar year basis.

Developmental Delay
The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury. Services rendered should be to treat or promote recovery of the specific functional deficits identified.

Durable Medical Equipment
Equipment, as determined by the Medical Claims Administrator, which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally or use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date
The date for which the Program Administrator approves enrollment in coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Program Administrator approves each future Participant according to its normal procedures.

Experimental or Investigational
Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence. Medical and scientific evidence means:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikcus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);
- Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t)(2) of the Social Security Act;
- The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
- It meets the following five technology assessment criteria:

- The technology must have final approval from the appropriate government regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology of health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternative.
- The technology must be beneficial in practice.

Freestanding Ambulatory Facility (Surgi-Center) and other Site of Service Providers
Freestanding Ambulatory Facility is a facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis; no patients stay overnight. The facility offers continuous service by both Physicians and Registered Nurses (R.N.s). It must be licensed by the appropriate state agency, licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Medical Claims Administrator. A Physician's office does not qualify as a Freestanding Ambulatory Facility. A Freestanding Ambulatory Facility is a type of Site of Service Provider.

Site-of-Service (SOS) Providers are surgical, lab, radiology and diagnostic imaging centers that meet cost and other criteria established by the Medical Claims Administrator. They are:

- A Provider that is not part of or owned by a Hospital and bills independently (i.e. not under a Hospital's name or ID number.) Providers such as Radiology Providers, Reference Laboratories, and Ambulatory Surgery Centers meet these criteria and are considered "freestanding" Site-of-Service Providers.
- An outpatient Facility location owned by a Hospital that is contracted with Anthem and meets the criteria to be considered "Site-of-Service" ("SOS").

These entities provide health care services such as surgery, laboratory tests, radiology and other services that are typically lower cost options for patients. Each participating Facility is subject to specific licensing, accreditation and credentialing requirements.

Home Health Care
Care, by a state-licensed program or provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

Home Health Care Agency
A provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate state agency, licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Medical Claims Administrator. It must be licensed by the appropriate state agency.

Hospital
A Provider licensed and operated as required by law which has:

- Room, board and nursing care;
- A staff with one or more Physicians on hand at all times;

- 24 hour nursing service;
- All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
- Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care
- Subacute care

Identification Card
The latest medical benefit card given to you showing your member and group numbers, the type of coverage you have and the date coverage became effective.

Ineligible Provider
Relative or person living in your home, a provider who no longer holds a valid license, or a provider who has been determined by the Medical Claims Administrator to have been involved in fraud or abuse activities related to the submission of claims.

Infertile or Infertility
The condition of a presumably healthy Participant who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

In-Network Provider
See the definition of “Maximum Allowed Amount.”

Injury
Bodily harm from a non-occupational accident.

Inpatient
A Participant who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive Care Unit
A special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

Maternity Care
Obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother’s Hospital stay is a covered benefit and the newborn infant is an eligible Participant under the Plan.

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

- That meet the definition of Covered Services, to the extent such services and supplies are covered under the 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 the Plan.

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

When you receive Covered Services, the Medical Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the determination of the Maximum Allowed Amount. The application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means the Medical Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, the Maximum Allowed Amounts may be reduced 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.

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

An **In-Network Provider** is a provider who is in the managed network for this specific Plan option or in a special Center of Excellence/or other closely managed specialty network. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Plan option is the rate the provider has agreed to accept as reimbursement for the Covered Services. Because In-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 (Balance-Bill). 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 the member services phone number on your medical Identification Card for help in finding an In-Network Provider or visit www.Anthem.com.

All other providers are **Out-of-Network Providers**, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

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

Administrator:

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

- 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 Medical Claims Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

- 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

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

- An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

The Maximum Allowed Amount for Out-of-Network Providers who are contracted with the Medical Claims Administrator for the Medical Claims Administrator's indemnity product network (Non-Preferred Providers) will be one of the five methods shown above unless the contract between the Medical Claims Administrator and that provider specifies a different amount. This type of provider may not send you a bill and collect for the amount of his or her charge that exceeds the Maximum Allowed Amount.

Except as described above, Out-of-Network Providers may send you a bill and collect for the amount of the provider's charge that exceeds the 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 an In-Network Provider will likely result in lower out of pocket costs to you. Please call the member services phone number on your medical Identification Card for help in finding an In-Network Provider or visit www.Anthem.com.

Member services staff are also available to assist you in determining this Plan option's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order 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 staff 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 certain Covered Services, 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 an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits for your cost share responsibilities and limitations, or call the member services phone number on your medical Identification Card 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 an In-Network Provider or an Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your benefit caps or day/visit limits.

Medical Claims Administrator
Anthem BlueCross BlueShield of Georgia is the Medical Claims Administrator.

Medical Necessity or Medically Necessary
The Medical Claims Administrator reserves the right to determine whether a service or supply is Medically Necessary. The fact that a Physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary.

The Medical Claims Administrator considers a service Medically Necessary if it is:

- appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
- compatible with the standards of acceptable medical practice in the United States;
- not provided solely for your convenience or the convenience of the Physician, health care provider or Hospital;
- not primarily Custodial Care; and
- provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms. For example, a Hospital stay is necessary when treatment cannot be safely provided on an outpatient basis.

Mental Health Disorders
Includes (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions and drug, alcohol or Chemical Dependency. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, Chemical Dependency disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

Non-Covered Services
Services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

Out-of-Network Provider
See the definition of "Maximum Allowed Amount."

Participant
The Employee and each eligible dependent, as defined in this booklet, while such person is covered by this Plan.

Participating Employer
An Employer who is eligible to participate as a member employer in the Georgia Municipal Employees Benefit System Health Plan and who has completed the documents required by the Program Administrator for participation in the Plan.

Physical Therapy
The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care. This service could be provided or prescribed, overseen and billed for by the Physician, or given by a physiotherapist on an Inpatient basis on the orders of a licensed Physician and billed by the Hospital.

Physician
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) approved by the Composite State Board of Medical Examiners, any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery. Optometrists and Clinical Psychologists are also considered covered providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

Physician Assistant (PA) - an individual duly licensed by the State of Georgia to provide basic medical services under the supervision of a licensed Physician.

Plan
The arrangement chosen by the Plan Sponsor to fund and provide for delivery of group health benefits to eligible Employees of Participating Employers, as set forth in the Participating Employer's Declaration Page and Retiree Annuitant Coverage Declaration Page (if applicable).

Plan Documents
The documents that contain the terms and conditions of the Plan. These documents include the State statutes that establish the Plan, and your Employer's Declaration Pages pertaining to this Plan that are filed with and accepted by the Program Administrator. These Declaration Pages describe which individuals are eligible for the Plan. Plan Documents also include documents that set forth the premiums required for participation in the Plan. These premium documents are maintained solely by the Employer, and are not approved by the Plan Sponsor or Program Administrator. Plan Documents include clinical guidelines that Claims Administrators follow when administering claims. The terms and conditions of the Plan are summarized in this Booklet and in the Plan's Summary of Benefits and Coverage and in the Schedule of Benefits. In the event of ambiguity or conflict between this Booklet or the Summary of Benefits and Coverage or the Schedule of Benefits and the Plan Documents, the Plan Documents control.

Plan Sponsor
Georgia Municipal Employees Benefit System (GMEBS) is the Plan Sponsor.

Respite Care
Care furnished during a period of time when the Participant's family or usual caretaker cannot, or will not, attend to the Participant's needs.

Schedule of Benefits
The Schedule of Benefits describes available benefits and cost sharing requirements. It also includes visit limits and other requirements that are specific to particular benefits. The **Schedule of Benefits** is posted under Benefits Booklets on the web at www.gacities.com/LHForms.

Semiprivate Room
A Hospital room which contains two or more beds.

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 on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by the Claims Administrator. A Skilled Nursing Facility gives the following:

Inpatient care and treatment for people who are recovering from an illness or injury; Care supervised by a Physician; 24 hour per day nursing care supervised by a full-time registered nurse. A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of alcohol or drug dependency; or a place for rest, educational, or similar services.

Urgent Care Center
A facility, appropriately licensed and meeting the Claims Administrator's standards for an Urgent Care Center, with a staff of Physicians, at which urgently-needed medical procedures are performed on an outpatient basis--no patients stay overnight. The facility offers continuous service by both Physicians and registered nurses (R.N.s). A Physician's office does not qualify as an Urgent Care Center.

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

You or Your
Refers to the Employee Participant and/or each Covered Dependent as applicable.

PHARMACY BENEFITS Administered by Aetna

13. How the Plan's Pharmacy Benefit (the Prescription Drug Program) Works.

This Section of the Booklet describes the Plan's Pharmacy benefits, which are referred to as the Prescription Drug Program. Under this Plan, you pay the Prescription Drug Copayment shown in the **Schedule of Benefits** per prescription or prescription refill and the Plan pays the balance.

At the time the prescription is dispensed; present your pharmacy Identification Card at the participating pharmacy. The participating pharmacist will complete and submit the claim for you. If you do not go to a participating pharmacy, you will need to submit the itemized bill to be processed.

Prescription Drug Benefits

The Prescription Drug Program provides coverage for drugs, which, under federal law, may only be dispensed with a prescription written by a Physician.

Insulin, which can be obtained over the counter, will only be covered under the Prescription Drug Program when accompanied by a prescription.

Under the Prescription Drug Program, the maximum supply that may be dispensed at either a retail pharmacy or through mail order; and the associated Copayment(s) are shown in the Schedule of Benefits. Drug quantities may not exceed quantity limits set forth in the Drug Formulary.

This Plan allows for refills of a prescription within one year of the original prescription date, as authorized by your Physician.

A limited number of Prescription Drugs require pre-authorization for Medical Necessity. If pre-authorization is not approved, then the designated drug will not be eligible for coverage. If pre-authorization is properly obtained, then the drug will be considered covered at the applicable co-payment. To determine if a drug requires pre-authorization, please call Pharmacy Claims Administrator's Customer Service Call Center or review the Drug Formulary on www.aetna.com/formulary (choose Aetna Commercial, then choose Three Tier Open Formulary Self-Insured).

Preferred Drug List (Drug Formulary)

Retail prescription medications shall, in all cases, be dispensed according to the Preferred Drug List (Drug Formulary) for prescriptions written and filled In- and Out-of-Network. The Preferred Drug List (Drug Formulary) may be amended from time to time by the Pharmacy Claims Administrator.

A Participant or prospective Participant shall be entitled upon request, to a copy of the Preferred Drug List (Drug Formulary Guide), available by calling the Pharmacy Claims Administrator's Customer Service Call Center, or by viewing www.aetna.com/formulary (choose Aetna Commercial, then choose Three Tier Open Formulary Self-Insured).

Maintenance drugs are available via mail order. To determine if a drug is considered a maintenance drug, please call the Pharmacy Claims Administrator's Customer Call Center. If a particular drug is not identified as a maintenance drug, then it is not available through mail order.

Preventive Care Medications

Preventive Care Medications are those medications that are obtained at a participating pharmacy with a Prescription order or refill from a physician and that are payable at 100% of the Prescription Drug charge (without application of any Co-payment) as required by applicable law under any of the following: with respect to infants, children and adolescents, evidence- informed preventive care provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. Preventive Care Medications include nicotine replacement therapy when prescribed for smoking cessation. These include:

bupropion HCl (smoking deterrent) tab SR,* nicotine TD patch, nicotine polacrilex gum, nicotine polacrilex lozenge
CHANTIX, NICOTROL INHALER, NICOTROL NS
Limits apply
* Only when prescribed for smoking cessation.

You may determine whether a drug is a Preventive Care Medication by calling the toll-free telephone number on your pharmacy Identification Card. For these Preventive Care Medications to be covered, you must obtain a prescription from your Physician and meet the age/gender or other requirements.

Prescription Drug Products from Pharmacy Claims Administrator's Mail Order Program

The quantity limits forth in the Schedule of Benefits apply for benefits for outpatient Prescription Drug Products dispensed by the Pharmacy Claims Administrator's mail order pharmacy:

As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on quantity limits. Your Physician must write your prescription for a 90-day or 3-month supply with refills when appropriate (not a 1-month supply with three refills).

Note: You will be charged a 90-day Co-payment regardless of the days' supply actually dispensed.
To fill the prescription, you may:

- Physician Mail your prescription(s) along with the required form in the envelope provided with your Welcome Package.
- Ask your Physician to call 1-877-270-3317 for instructions on how to fax the prescription. Your Physician must include your Member ID number.
- Login to the Pharmacy Claims Administrator's website, www.aetna.com, and place your order.

Note: If you submit a prescription for a 1-month supply to the Pharmacy Claims Administrator's mail order pharmacy, it will be filled but you will be charged the 90-day Co-payment amount, so make sure you submit only maintenance prescriptions that you take on a regular basis for a full 90-day supply.

Specialty Prescription Drug Products from Pharmacy Claims Administrator's Specialty Pharmacy

Specialty medications are drugs that are used to treat complex conditions, such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. Whether the drugs are administered by a healthcare professional, self-injected or taken by mouth, specialty medications require an enhanced level of service. Drugs which have been identified as Specialty Prescription Drugs for your benefit plan may be viewed when you log in to the Pharmacy Claims Administrator's website, www.aetna.com. Your prescriptions may be filled through the Pharmacy Claims Administrator's Specialty Pharmacy home delivery program if you have a prescription for one of these products. Through this program

you will receive clinical support and monitoring .Specialty medicine can be hard to get used to. You can work with Aetna's nurses and pharmacist to get all the help you need. Support could include: Training to self-inject drugs, coping with side effects, coordination of home health care, if needed Follow-up with prescribing doctors

Out-of-Network Pharmacy Notification or If You Do Not Present Your Pharmacy Identification Card

If a prescription is filled by an out-of-network pharmacy or without use of your pharmacy Identification Card you can submit that claim for reimbursement up to twelve (12) months after the date the prescription was filled. If the drug required notification approval and that was not obtained prior to filling the prescription then it can be requested at the time the claim is submitted. If the notification is not approved, then you will not be able to be reimbursed for your claim.

When you submit a claim on this basis, you may pay more because you did not notify the Pharmacy Claims Administrator before the Prescription Drug Product was dispensed and because the out-of-network pharmacy you used is not bound by the network pricing under our plan. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required cost sharing amount. If you wish to seek reimbursement, you may obtain a prescription drug claim form from the Pharmacy Claims Administrator by calling the number on your Pharmacy ID card, or logging into www.aetna.com.

Along with the prescription drug claim form, you will need a pharmacy receipt for your prescription and if applicable- an explanation of benefits (EOB) from your primary carrier. The prescription drug claim form must be filled out in its entirety and mailed to the address on this form. Any missing information may cause a delay in processing your reimbursement. Required information includes the pharmacy seven-digit NCPDP number (this number should be identified on your pharmacy receipt), the National Drug Code (NDC) number for your prescription (this can be obtained from your pharmacy), the prescription number, the name of the pharmacy, the physician's name, the member ID number, and the patient's name and date of birth. A pharmacy receipt and an EOB from your primary carrier (if applicable) will also be required along with the claim form.

You will be reimbursed the approved Prescription Drug cost less the applicable cost sharing amount. Also, you are subject to Benefit plan rules (including, but not limited to, step therapy and quantity limits) as well as balance billing if the charged amount exceeds the network cost of your prescription(s).

14. Frequently Asked Questions about Pharmacy Benefits

What are the quantity limit (QL) programs?

The QL program defines the maximum quantity that can be dispensed per Co-payment (Quantity Level Limit, or QLL) or specified time frame (Quantity Duration, or QD). Quantity limits are based upon the manufacturer's package size, dosing recommendations or guidelines that are included in the FDA.

How do the QL programs work?

If your prescription exceeds the quantity limit, your pharmacist will be notified of the quantity covered for your Co-payment. You will have the following options:

- Accept the established quantity limit
- Pay additional out-of-pocket costs that exceed the quantity limits (as appropriate)
- Discuss alternatives with your Physician before deciding whether to fill the prescription

What is a Coverage Review or Prior Authorization?

A coverage review or Prior Authorization (PA) is a set of clinical rules designed to support the Pharmacy benefits under the Plan at the time the prescription is dispensed. Applied to a limited number of medications, Prior authorization requires your Physician to provide additional information to determine whether the use of the medication is covered by your Plan and to ensure appropriate use.

How does the Prior Authorization Program work?

If your medication is included in the prior authorization program, your pharmacy is sent a message on the computer system with instructions to have your Physician call a toll-free number to get approval for the prescription. Some Pharmacists will contact your Physician while others may request you do so. Your Physician will provide the Pharmacy Claims Administrator with information to determine if the prescription meets the coverage conditions of your Pharmacy Benefit. The Pharmacy Claims Administrator will review the information and approve or deny coverage, and will send letters to you and your Physician explaining the decision and providing instructions on how to appeal if you so desire.

What is a maintenance medication program?

Maintenance Prescription Drug Products are long-term medications taken to treat an ongoing condition, such as high blood pressure, high cholesterol or diabetes. Maintenance medications are those prescribed medications that a member may obtain for a period of up to 90 days per fill.

You may obtain up to a 90-day supply if your Physician writes a prescription for a 90-day supply. For example, if you take two tablets a day, your Physician must write a prescription for a quantity of 180 tablets to be dispensed.

Please log in to www.aetna.com or call the Pharmacy Claims Administrator member services number if you have specific questions regarding whether a medication is covered as a maintenance medication.

Which maintenance medications are included in the maintenance medication program?

Maintenance medications include but are not limited to:

- Anti-Parkinson medications
- Asthma medications that are taken orally, excluding inhalers
- Cardiovascular medications for hypertension and heart disease and cholesterol
- Diabetic medications
- Estrogen and progestin medication
- Medications for the treatment of epilepsy
- Oral contraceptives
- Thyroid medications
- Glaucoma
- Antipsychotics
- Alzheimer’s
- Depression
- Osteoporosis

Step Therapy Program Requirements

Certain Prescription Drug Products are subject to Step Therapy Program requirements (also known as Step Therapy). This means that in order to receive benefits for such Prescription Drug Products or Pharmaceutical Products, you are required to use (a) different Prescription Drug Product(s) or Pharmaceutical Product(s) first. You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to Step Therapy requirements by logging in to www.aetna.com or by calling the member services number on your Pharmacy ID card.

What is a Prescription Drug List (PDL) or Formulary?

A PDL is a list of FDA-approved Brand-name and Generic medications. The PDL is one way you can find out the tier status and specific rules linked to your medication. The PDL lists the most commonly prescribed medications for certain conditions.

The PDL offers a wide choice of Brand-name and Generic medications that are reviewed by Physicians and Pharmacists of the PBM. The list is updated to reflect decisions based on new medical evidence and information. Additionally, the FDA approves all medications, including Generics, which means you can be confident that whatever medication you choose, it meets the strict guidelines set by the FDA.

Your Pharmacy Benefit provides coverage for a comprehensive selection of prescription medications. You can check which medications are on which tiers by logging in to www.aetna.com. You and your physician can refer to this list to consider prescription medication choices and select the appropriate medication to meet your needs.

Understanding Tiers

Prescription medications are categorized within tiers which are determined by the Pharmacy Claims Administrator. Each tier is assigned a Co-payment, the amount you pay when you fill a prescription, which is determined by the Plan. Consult your **Schedule of Benefits** to find out the specific Co-payments that are part of your plan. You and your Physician decide which medication is appropriate for you.

Coordination of Pharmacy Benefits between your Primary Prescription Drug Plan (PDP) and this Plan

If you have another health plan with pharmacy benefits as primary, each time you go to the pharmacy, present both your primary insurance carrier and this Plan's Pharmacy ID cards.

When COB occurs, you should not be responsible for more than your Plan's Co-payment for eligible charges.

Note: To be eligible for reimbursement when coordinating pharmacy benefits with your primary insurance carrier, it is your responsibility to make sure any prescriptions subject to specific benefits rules, such as Prior Authorization and Step Therapy, receive approval before your claims may be considered for reimbursement. To request a secondary payment from the Pharmacy Claims Administrator after the time of purchase, you can send a prescription drug claim form and attach a copy of the EOB from the primary plan and the pharmacy receipt. You can obtain a copy of the prescription drug claim form by calling the member services number on your Pharmacy ID card, or by logging in to www.aetna.com. When this Plan is the secondary plan, benefits are coordinated to pay only the difference between the amount paid by the primary plan and the allowable amount payable by this Plan. Co-payments will be required for each filled prescription.

15. Pharmacy Benefit Limitations and Exclusions

The following are <u>not</u> Covered Services under this Plan:

- Prescription Drug Products for the amount dispensed (days' supply or quantity limit) that exceeds the day limit, dollar limit, or quantity limit stated in Plan Documents, which include the Drug Formulary, or the limits established through any pre-certification or pre-authorization.
- Prescription Drugs received through an Internet pharmacy provider except for Aetna's mail order and specialty pharmacies.
- General vitamins except the following, which require a prescription: prenatal vitamins, vitamins with fluoride and single-entity vitamins.
- Smoking cessation products, except as described under Preventive Care Services.
- Drugs available over-the-counter that do not require a prescription by federal or state law before being dispensed except for certain preventive OTC drugs – aspirin, fluoride, folic acid and Iron – that require a prescription for coverage.
- Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this booklet, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.
- Medications used for cosmetic purposes (e.g., Propecia, Rogaine).
- Appetite Suppressants (Anorexiants).
- Weight Loss Products.
- Diet supplements.
- Syringes (for use other than insulin).
- The administration or injection of any prescription Drug or any drugs or medicines (except when approved by pre-certification).
- Prescription Drugs which are entirely consumed or administered at the time and place where the prescription order is issued.
- Prescription refills in excess of the number specified by the Physician, or any refill dispensed after one year from the date of the prescription order.
- Prescription Drugs for which there is no charge.
- Charges for items such as therapeutic devices, artificial appliances, or similar devices, regardless of their intended use.
- Drugs that are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility or Alternate Facility.
- Charges for delivery of any Prescription Drugs purchased at a retail pharmacy or expedited delivery.
- Drugs and medicines which do not require a prescription order and which are not Prescription Drugs.
- Prescription Drugs provided by a Physician whether or not a charge is made for such Prescription Drugs.
- Prescription Drugs which are not Medically Necessary or which the Pharmacy Claims Administrator determines are not consistent with the diagnosis.
- Prescription Drugs, which the Pharmacy Claims Administrator determines, are not provided in accordance with accepted professional medical standards in the United States.
- Any services or supplies, which are not specifically listed as covered under this Prescription Drug program.
- Prescription Drugs which are Experimental or Investigational in nature as explained in the "Limitations and Exclusions" section. This exclusion will not apply with respect to drugs which either: 1) have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or 2) are being studied at the Phase III level

in a national clinical trial sponsored by the National Cancer Institute AND which are determined by the Pharmacy Claims Administrator based on available scientific evidence to be effective or show promise of being effective for the illness.

- Prescription Drugs used to treat impotency or other sexual dysfunction or inadequacies.
- Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes. The one exception is for the correction of congenital birth defects.
- Prescription Drug Products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- An injectable Prescription Drug Product (including, but not limited to, immunizations and allergy serum) that, due to its characteristics as determined by the Pharmacy Claims Administrator, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to covered self-administered injectable medications and Specialty medications.
- The cost of labor and additional charges for compounding prescriptions, excluding contractual dispensing fees that Pharmacies charge.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- Prescription Drug Products when prescribed to treat infertility.
- Compounded drugs that do not contain at least one covered ingredient that requires a prescription.

15. Pharmacy Benefit Claims and Appeals

How to File Pharmacy Benefit Claims

In-Network: If you receive care from an In-Network Provider, the In-Network Provider will file claims for you.

Out-of-Network: If you do not use a network pharmacy, you must file the claim with the Pharmacy Claims Administrator. Prescription Drug receipts must show the prescription number and name of the drug, date of purchase, quantity, charge and the prescribing Physician's name.

Out-of-State and Out-of-Country: Please contact the Customer Service number on your Pharmacy Benefits Identification Card for information about how to file claims when you obtain prescription drug services out of the state of Georgia or out of the United States.

Pharmacy Benefit Claim Appeals Procedures

The Pharmacy Claims Administrator has discretion to interpret the terms of the Plan that pertain to payment of pharmacy claims, and is solely responsible for administering all pharmacy claims and making all decisions related to pharmacy claims. For purposes of the claims and appeals procedures described in this section, the term "Claims Administrator" refers to Aetna.

Appeal of Denial to Claims Administrator

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, use Appeal Form:
https://member.aetna.com/memberSecure/assets/pdfs/forms/68192.pdf

- How to ask for an appeal by phone.

  To request an appeal by phone, call Member Services. The toll-free telephone number is on your member ID card. If you're hearing impaired you can call TTY: 711 for Telecommunication Relay Services (TRS). Member Services can also help you with the process of naming an authorized representative.

- How to ask for an appeal in writing.

  You or your authorized representative can mail us your request for an appeal. To do so, send a letter or a completed Member Complaint and Appeal Form to the address below. The form is online at: https://member.aetna.com/memberSecure/assets/pdfs/forms/68192.pdf. Send your request to:

  Aetna
  Customer Resolution Team
  P.O. Box 14625
  Lexington, KY 40512

  Your request should include:
  - Your name
  - Your member ID number (or date of birth) or other identifying information
  - The group's name (for example, if you are covered by your employer)
  - Comments, documents, records and other information you want us to consider

  You may also ask us for documents that are relevant to the unfavorable decision for your review. These are free. Call Member Services to ask for them. The toll-free phone number is on your member ID card.

- For urgent appeals, we can deliver a faster decision.
  An urgent appeal is one where your doctor believes a delay in making a decision could put your life, health or ability to regain full function at serious risk, or could cause you severe pain. If your appeal is urgent you, your doctor or other authorized representative can request a faster review. To do this, call the National Clinical Appeal Unit expedited appeal toll-free number at 1-800-243-5349. You can also fax your request to 1-877-867-8372. (If the Urgent appeal submitted does not meet the criteria, it will move to the standard process and standard turn around)

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

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

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 Claim Administrator's final decision on the claim or other request for benefits. If the Claims Administrator decides an appeal is untimely, the Claim Administrator's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust this Plan's internal appeals procedure before filing a lawsuit or taking other legal action of any kind against the Plan.

Unless the exception in the following paragraph applies, if the Claims Administrator fails to strictly adhere to all the requirements with respect to your claim under the internal claims and appeals rules of this Section, you will be deemed to have exhausted the internal claims and appeals process with respect to such claim. Accordingly, you may initiate an external review of the claim, as outlined above. You are also entitled to pursue any available remedies under state law with respect to the claim.

Notwithstanding the previous paragraph, the internal claims and appeals process will not be deemed exhausted based on *de minimis* (or insignificant) violations that do not cause you, and are not likely to cause you, prejudice or harm, so long as the Claims Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Claims Administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between you and the Claims Administrator. This exception is not available if the violation is part of a pattern or practice of violations by the Claims Administrator. You may request a written explanation of the violation from the Claims Administrator, and the Claims Administrator will provide such explanation within 10 days, including a specific description of the basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If the IRO or a court rejects your request for immediate review due to deemed exhaustion on the basis that the Claims Administrator met the standards for the exception described in this paragraph, you will have the right to resubmit and pursue the internal appeal of the claim. In such case, within a reasonable time after the IRO or court rejects the claim for immediate review (not to exceed 10 days), the Claims Administrator will provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re- filing the claim will begin to run upon your receipt of such notice.

Form and Manner of Notices

Notices provided pursuant to this Section with respect to internal claims and appeals and external reviews will be provided in a culturally and linguistically appropriate manner pursuant to U.S. Department of Health and Human Services regulations. Accordingly, with respect to an address in any United States county to which a notice is sent, if 10% or more of the population residing in the county is literate only in the same non-English language (the "applicable non-English language"), the Claims Administrator will: (i) provide oral language services (such as a telephone customer assistance hotline) that include answering questions in the applicable non-English language; (ii) provide notices sent under this Section in the applicable non-English language upon request; and (iii) include a statement in the English versions of all notices sent under this Section, prominently displayed in the applicable non- English language, clearly indicating how to access language services provided by the Plan.

Effect of Federal Guidance on this Section

Any information, processes, standards of review, or other elements that are required to be provided under this Section shall be provided or applied only if the Plan is required to do so under applicable legal requirements and the U.S. Department of Health and Human Services is currently enforcing such requirements. For these purposes, the Plan may rely fully on the U.S. Department of Health and Human Services Technical Guidance published on June 22, 2011, the U.S. Department of Labor 2011 amendment to the interim final regulations published on July 23, 2010, and any subsequent guidance.

Complaints about Pharmacy Network Provider Service

If your complaint involves care received from a provider, please call the Customer Service Call Center on your Identification Card. Your complaint will be addressed in a timely manner.

Plan's Right of Reimbursement

If the amount of the payment made by us is more than it should have paid under this provision, we may recover the excess from one or more of:

- the persons we have paid or for whom we have paid,
- insurance companies, or
- other organizations.

If there is a conflict between the policies, procedures and timeframes in this section and the requirements of applicable law, the Claims Administrator will follow the requirements of applicable law.

16. Pharmacy Benefit Definitions

All words capitalized in this Pharmacy Benefits Section of the Booklet and not defined elsewhere have the meanings set forth below.

Formulary, Preferred Drug Formulary, Formulary or Drug Formulary
A document setting forth certain rules relating to the coverage of pharmaceuticals, that may include but not be limited to (1) a listing of preferred prescription medications that are covered and/or prioritized in order of preference by the Pharmacy Claims Administrator, and are dispensed to Participants through pharmacies that are Network Providers, and (2) pre-certification rules. This list is subject to periodic review and modification. Charges for medications may be ineligible, in whole or in part, if a Participant selects a medication not included in the Formulary.

Brand Name Drug
A Prescription Drug with a proprietary name assigned to it by the manufacturer and distributor. Brand Name Drug does not include those drugs classified as a Generic Drug.

Generic Drugs
A Prescription Drug, whether identified by its chemical, proprietary, or non-proprietary name that (a) is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient, or (b) is deemed to be pharmaceutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

Identification Card
The latest pharmacy benefit card given to you showing your member and group numbers, the type of coverage you have and the date coverage became effective.

Pharmacy Claims Administrator
Aetna is the Pharmacy Claims Administrator.

Prescription Drug
A drug or Prescription Drug Product which cannot be purchased except with a prescription from a Physician.

Prescription Drug Product
A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a prescription. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver or a skilled caregiver in the case of certain Specialty medications. For the purpose of Benefits under the plan, this definition includes:

- Inhalers (with spacers)
- Insulin
- The following diabetic supplies: Insulin syringes with or without needles Urine/Blood Test Strips & Tapes
- Lancets
- Blood Glucose Testing monitors
- Continuous Glucose Monitor/Transmitters/Sensors