MEDICAL BENEFIT BOOKLET

For

BALL STATE UNIVERSITY RETIREE HEALTH PLAN

Administered By

Ball State University®

If you need assistance in Spanish to understand this document, you may request it for free by calling Customer Service at the number on your identification card.

Effective 1-1-16
This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the Ball State University Retiree Health Plan (the “Plan”) offered by Ball State University (the “University”). You should read this Benefit Booklet carefully to familiarize yourself with the Plan’s main provisions and keep it handy for reference. A thorough understanding of Your coverage will enable You to use Your benefits wisely. If You have any questions about the benefits as presented in this Benefit Booklet, please contact the University's Payroll & Employee Benefits or call the Claims Administrator’s Customer Service Department.

The Plan provides the benefits described in this Benefit Booklet only for eligible persons. The health care services are subject to the Limitations and Exclusions, Copayments, Deductible, and Coinsurance requirements specified in this Benefit Booklet. Any group plan or certificate which You received previously will be replaced by this Benefit Booklet.

Anthem Blue Cross and Blue Shield, or “Anthem” has been designated by the University to provide administrative services for the Plan, such as claims processing, care management, and other services, and, for the Under 65 Retiree options, to arrange for a network of health care providers whose services are covered by the Plan.

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

Anthem is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, permitting Anthem to use the Blue Cross and Blue Shield Service Marks in portions of the State of Indiana. Although Anthem is the Claims Administrator and is licensed in Indiana, You will have access to providers participating in the Blue Cross and Blue Shield Association BlueCard® PPO network across the country. Anthem has entered into a contract with the University on its own behalf and not as the agent of the Association.

Verification of Benefits
Verification of benefits is available for Covered Persons or authorized healthcare Providers on behalf of Covered Persons. You may call Customer Service with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 8:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. CALL THE CUSTOMER SERVICE NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.
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<th>Page</th>
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As a Member You have rights and responsibilities when receiving health care. As Your health care partner, the Claims Administrator wants to make sure Your rights are respected while providing Your health benefits. That means giving You access to the Claims Administrator’s network health care Providers and the information You need to make the best decisions for Your health. As a Member, You should also take an active role in Your care.

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

**You have the responsibility to:**
- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health Plan rules and policies.
- Choose a Network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider’s office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don’t understand any type of care you’re getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give the Claims Administrator, Your Doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health Plan. This may include information about other health insurance benefits You have along with Your coverage with the Plan.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.
If you would like more information, have comments, or would like to contact the Claims Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your identification card.

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

How to Obtain Language Assistance
Anthem is committed to communicating with our covered persons about the Plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our customer service call centers. Simply call the customer service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting customer service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.
SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Plan; are Medically Necessary; and are provided in accordance with the Plan. See the Definitions and Claims Payment sections for more information. Under certain circumstances, if the Claims Administrator pays the healthcare provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

I. SCHEDULE OF BENEFITS FOR UNDER 65 RETIREES

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Deductible Wellness PPO Plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Calendar Year Deductible – Combined Limit Applies

<table>
<thead>
<tr>
<th>Category</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$1,300</td>
<td>$2,600*</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$3,900</td>
<td>$7,800*</td>
</tr>
<tr>
<td>Family</td>
<td>$3,900</td>
<td>$7,800*</td>
</tr>
</tbody>
</table>

Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.

All Covered Services are subject to the Deductible unless otherwise specified in this booklet.

*Amounts satisfied toward the Network calendar year Deductible will be applied toward the Out-of-Network calendar year Deductible and amounts satisfied toward the Out-of-Network calendar year Deductible will be applied toward the Network calendar year Deductible.

Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)

<table>
<thead>
<tr>
<th>Category</th>
<th>Plan Pays</th>
<th>Covered Person Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>50%</td>
</tr>
</tbody>
</table>

All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.
### Schedule of Benefits
High Deductible Wellness PPO Plan

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket Maximum Per Calendar Year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes all Coinsurance, Copayments and the Deductible amounts you incur in a Benefit Period, except prescription drug benefits, precertification penalties, or charges in excess of the Maximum Allowed Amount or Non-Covered Services. Once the Out-of-Pocket Maximum is satisfied, no additional Coinsurance or Copayment will be required for the Covered Person for the remainder of the Benefit Period except for the services listed above.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>$4,050</td>
<td>$12,150</td>
</tr>
<tr>
<td><strong>Employee + Children</strong></td>
<td>$9,750</td>
<td>$29,250</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$9,750</td>
<td>$29,250</td>
</tr>
</tbody>
</table>

Amounts satisfied toward the Network Out-of-Pocket Maximum will be applied toward the Out-of-Network Out-of-Pocket Maximum and amounts satisfied toward the Out-of-Network Out-of-Pocket Maximum will be applied toward the Network Out-of-Pocket Maximum.

When a Covered Person satisfies the individual Out-of-Pocket Maximum, the Plan pays 100% of the cost for Covered Services for the remainder of the Plan year for that Covered Person, and when the family Out-of-Pocket Maximum is satisfied by a Covered Person or Covered Persons, the Plan pays 100% of the cost for Covered Services for all Covered Persons for the remainder of the Plan year for all Covered Persons.

### Allergy Care

- Testing – Physician or specialist Physician: 20% Network, 50% Out-of-Network
- Treatment – Physician: 20% Network, 50% Out-of-Network
- Treatment – specialist Physician: 20% Network, 50% Out-of-Network
- Serum and allergy shots – Physician or specialist Physician: 20% Network, 50% Out-of-Network

### Behavioral Health / Substance Abuse Care

- Hospital Inpatient Services: 20% Network, 50% Out-of-Network
- Outpatient Services: 20% Network, 50% Out-of-Network
- Physician Services (Home and Office Visits): 20% Network, 50% Out-of-Network

Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided to the same extent and degree as for the treatment of physical illness and in compliance with state and federal law.
# Schedule of Benefits

**High Deductible Wellness PPO Plan**

<table>
<thead>
<tr>
<th>Clinical Trials</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please see Clinical Trials under Benefits section for further information.</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental &amp; Oral Surgery / TMJ Services</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accidental Injury to natural teeth - Treatment must be completed within 12 months of the Injury</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
</tr>
<tr>
<td>• Oral Surgery / TMJ - Subject to Medical Necessity – excludes appliances and orthodontic treatment</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic Physician’s Services</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>• Primary care Physician</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Specialist Physician</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Diagnostic X-ray – office</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Diagnostic Blood Work – LabCorp, Quest Diagnostics, American Health Network</td>
<td>Covered at 100%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Note:** Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.

<table>
<thead>
<tr>
<th>Emergency Room, Urgent Care, and Ambulance Services</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room for an Emergency Medical Condition</td>
<td>$200</td>
<td>(See note below)</td>
</tr>
<tr>
<td>Copayment then 20%</td>
<td>(Copayment waived if admitted)</td>
<td></td>
</tr>
<tr>
<td>All other services</td>
<td>$200</td>
<td>20%</td>
</tr>
<tr>
<td>(Copayment waived if admitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule of Benefits</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>High Deductible Wellness PPO Plan</strong></td>
<td>$200 Copayment then 20% (Copayment waived if admitted)</td>
<td>Covered at the Network benefit level</td>
</tr>
<tr>
<td>Emergency room visit (per visit) Coinsurance</td>
<td>$200 Copayment then 20% (Copayment waived if admitted)</td>
<td>(See note below)</td>
</tr>
<tr>
<td>All other services</td>
<td>20%</td>
<td>(See note below)</td>
</tr>
<tr>
<td>Urgent Care clinic visit for an Emergency Medical Condition Clinic visit (per visit) Coinsurance</td>
<td>20%</td>
<td>(See note below)</td>
</tr>
<tr>
<td>All other services</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Ambulance Services (when Medically Necessary) Land / Air</td>
<td>20%</td>
<td>(See note below)</td>
</tr>
</tbody>
</table>

**Note:** Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.

### Eye Care

- **Office visit – medical eye care exams (treatment of disease or injury to the eye)**
  - Primary care Physician Coinsurance: 20% 50%
  - Specialist Physician Coinsurance: 20% 50%
- **Treatment other than office visit**
  - Routine eye exams are not a Covered Service except for Preventive Care services for Children.

### Hearing Care

- **Office visit – Audiometric exam / hearing evaluation test**
  - Primary care Physician Coinsurance: 20% 50%
  - Specialist Physician Coinsurance: 20% 50%
- **Cochlear Implants**
  - 20% 50%
- **Hearing devices / hearing aids**
  - Not Covered
Schedule of Benefits  
High Deductible Wellness PPO Plan  

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine hearing exams are not a Covered Service except for Preventive Care services for Children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care Services</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bereavement is covered</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- Respite Care is covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Inpatient Services – Precertification Required</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Room and board (Semiprivate or ICU/CCU)</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient Physical Therapy, etc.)</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- Pre-Admission testing</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- Physician Services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Surgeon</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- Anesthesiologist</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- Radiologist</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- Pathologist</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>*Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services. <strong>If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity Care &amp; Other Reproductive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Physician’s office:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global care (includes pre-and post-natal, delivery) –</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Primary care Physician (includes obstetrician and gynecologist)</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>- Specialist Physician Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Midwife (Precertification required)</td>
<td>20%</td>
<td>50%</td>
</tr>
</tbody>
</table>
## Schedule of Benefits
### High Deductible Wellness PPO Plan

<table>
<thead>
<tr>
<th>Physician Hospital / Birthing Center Services (Precertification required)</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physician’s services</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Newborn nursery services (well baby care)</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Circumcision</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• <strong>Note:</strong> Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Infertility Services
- Covered for services to diagnose infertility only, treatment of infertility is not covered.
- Treatment for underlying medical conditions are covered as medical.

### Non-covered Services include
- but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.

### Sterilization Services (Precertification required for Inpatient procedures)
- Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section in Covered Services for further details.
- **Vasectomy** | 20% | 50% |

### Medical Supplies and Equipment
- **Medical Supplies** | 20% | 20% |
- **Durable Medical Equipment** | 20% | 20% |
- **Orthotics**
  - Foot and Shoe | 20% | 50% |
- **Prosthetic Appliances** (external) | 20% | 50% |
<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutritional Counseling for Diabetes</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Outpatient Hospital / Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient facility</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Lab and x-ray services</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Physician Services (Home and Office Visits)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Primary care Physician</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Specialist Physician</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Ball State Employee Quick Clinic</td>
<td><strong>Covered at 100%</strong></td>
<td>N/A</td>
</tr>
<tr>
<td>Office Surgery</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Online Visits</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Prescription Injectable Drugs / Prescription Drugs Dispensed in the Physician’s Office</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Note: Specialty should be sourced through Accredo (Express Scripts)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Services (regardless of Provider or setting where Preventive care is provided)</strong></td>
<td><strong>Covered at 100%</strong></td>
<td>Covered at the Out-of-Network benefit level</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Gastric Bypass / Obesity Surgery</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Therapy Services (Outpatient)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care Physician – Coinsurance, per visit</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Specialist Physician or other – Coinsurance per visit</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Physical Therapy – 60 day visit limitation</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Occupational Therapy – 60 day visit limitation</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Speech Therapy – 60 day visit limitation</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Cardiac Rehabilitation – 36 day visit limitation</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>Schedule of Benefits</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>---------</td>
<td>---------------</td>
</tr>
<tr>
<td>High Deductible Wellness PPO Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chiropractic Care – 24 day visit limitation</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Radiation Therapy</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Chemotherapy</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Respiratory Therapy</td>
<td>20%</td>
<td>50%</td>
</tr>
<tr>
<td>• Vision Therapy</td>
<td>20%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Note:** Inpatient therapy services will be paid under the Inpatient Hospital benefit.
## Schedule of Benefits
### High Deductible Wellness PPO Plan

<table>
<thead>
<tr>
<th>Transplants</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, <em>collection</em> and storage, including Medically Necessary preparatory myeloablative therapy.</td>
<td><strong>Center of Excellence/Network Transplant Provider</strong></td>
<td><strong>Out-of-Network Transplant Provider</strong></td>
</tr>
</tbody>
</table>

**The Center of Excellence requirements do not apply to** cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.

**Note:** Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Customer Service, ask to be connected with the Transplant Case Manager for further information.)

### Transplant Benefit Period

- **Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Customer Service number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)**
- **Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.**
**Schedule of Benefits**  
High Deductible Wellness PPO Plan

<table>
<thead>
<tr>
<th>Covered Transplant Procedure during the Transplant Benefit Period</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Care coordinated through a Network Transplant Provider/ Center of Excellence – not subject to Deductible</td>
<td>BDCT Facility 100% covered</td>
<td>BDCT Facility 100% covered</td>
</tr>
<tr>
<td>• When performed by Out-of-Network Transplant Provider (subject to Deductible, does not apply to the Out of Pocket Maximum). You are responsible for any charges from the Out-of-Network Transplant Provider which exceed the Maximum Allowed Amount.</td>
<td>Non-BDCT Facility 20%</td>
<td>Non-BDCT Facility Not Covered</td>
</tr>
<tr>
<td>• Bone Marrow &amp; Stem Cell Transplant (Inpatient &amp; Outpatient)</td>
<td>BDCT Facility 100% covered</td>
<td>BDCT Facility 100% covered</td>
</tr>
<tr>
<td>• Includes unrelated donor search up to $30,000 per transplant.</td>
<td>Non-BDCT Facility 20%</td>
<td>Non-BDCT Facility Not Covered</td>
</tr>
<tr>
<td>• Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)</td>
<td>Covered, as approved, up to a $17,500 benefit limit</td>
<td>Covered, as approved, up to a $17,500 benefit limit. You are responsible for 50% of search charges. These charges will NOT apply to the Out-of-Pocket Maximum.</td>
</tr>
<tr>
<td>• Eligible Travel and Lodging – Limited to $150/day with maximum of $2,500 for organ transplants Network and Out-of-Network subject to Claims Administrator's approval.</td>
<td>BDCT Facility 100% covered</td>
<td>BDCT Facility 100% covered</td>
</tr>
<tr>
<td>• All Other Covered Transplant Services</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
</tr>
</tbody>
</table>
### II. SCHEDULE OF BENEFITS FOR 65 AND OVER RETIREES

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
</tr>
<tr>
<td><strong>Individual</strong></td>
</tr>
<tr>
<td><strong>Family</strong></td>
</tr>
</tbody>
</table>

Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.

All Covered Services are subject to the Deductible unless otherwise specified in this Benefit Booklet.

<table>
<thead>
<tr>
<th><strong>Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Pays</strong></td>
</tr>
<tr>
<td><strong>Covered Person Pays</strong></td>
</tr>
</tbody>
</table>

**Out-of-Pocket Maximum**

Includes all Coinsurance, Copayments and the Deductible amounts you incur in a Benefit Period, except prescription drug benefits, precertification penalties, or charges in excess of the Maximum Allowed Amount or Non-Covered Services.

| **Individual**                      | $1,500 |
| **Family**                          | N/A    |

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergy Care</strong></td>
</tr>
<tr>
<td>• Testing</td>
</tr>
<tr>
<td>• Treatment</td>
</tr>
<tr>
<td>• Serum and allergy shots</td>
</tr>
<tr>
<td>Schedule of Benefits</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Behavioral Health / Substance Abuse Care</strong></td>
</tr>
<tr>
<td>Hospital Inpatient Services</td>
</tr>
<tr>
<td>Outpatient Services</td>
</tr>
<tr>
<td>Applied Behavioral Analysis (ABA) Therapy</td>
</tr>
</tbody>
</table>

**Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided to the same extent and degree as for the treatment of physical illness and in compliance with state and federal law.**

<table>
<thead>
<tr>
<th><strong>Clinical Trials</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Please see Clinical Trials under Benefits section for more information.</td>
</tr>
<tr>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dental &amp; Oral Surgery / TMJ) Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Accidental Injury to natural teeth Treatment must be completed within 12 months of the Injury</td>
</tr>
<tr>
<td>• Oral Surgery / TMJ - Subject to Medical Necessity – (surgical and non-surgical) appliances covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Diagnostic Physician’s Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:</td>
</tr>
<tr>
<td>• Diagnostic X-ray – office</td>
</tr>
<tr>
<td>• Diagnostic Blood Work – LabCorp, Quest Diagnostics, American Health Network</td>
</tr>
</tbody>
</table>

**Note:** Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.
## Schedule of Benefits

### Emergency Room, Urgent Care, and Ambulance Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Copayment / Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room for an Emergency Medical Condition</td>
<td>$200 Copayment then 20% (Copayment waived if admitted)</td>
</tr>
<tr>
<td>All other services</td>
<td>$200 Copayment then 20% (Copayment waived if admitted)</td>
</tr>
<tr>
<td>Use of the emergency room for non-Emergency Medical Conditions</td>
<td>$200 Copayment then 20% (Copayment waived if admitted)</td>
</tr>
<tr>
<td>Emergency room visit (per visit) Copayment / Coinsurance</td>
<td>$200 Copayment then 20% (Copayment waived if admitted)</td>
</tr>
<tr>
<td>All other services</td>
<td>$200 Copayment then 20% (Copayment waived if admitted)</td>
</tr>
<tr>
<td>Urgent Care clinic visit for an Emergency Medical Condition Clinic visit (per visit) Copayment / Coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td>All other services</td>
<td>20%</td>
</tr>
<tr>
<td>Ambulance services (when Medically Necessary) Land / Air</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Eye Care

- Office visit – medical eye care exams (treatment of disease or Injury to the eye) 20%
- Treatment other than office visit 20%

Routine eye exams are not a Covered Service.

### Hearing Care

- Office visit – Audiometric exam / hearing evaluation test 20%
- Cochlear Implants 20%
- Hearing devices / hearing aids Not Covered

Routine hearing exams are not a Covered Service.

### Home Health Care Services

- Private Duty Nursing only covered in the home. 20%

### Hospice Care Services

- Includes bereavement and respite care. 20%
### Schedule of Benefits

<table>
<thead>
<tr>
<th>Hospital Inpatient Services – Precertification Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Room and board (Semiprivate or ICU/CCU)</td>
</tr>
<tr>
<td>• Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient physical therapy, etc.)</td>
</tr>
<tr>
<td>• Pre-Admission testing</td>
</tr>
<tr>
<td>• Physician Services:</td>
</tr>
<tr>
<td>► Surgeon</td>
</tr>
<tr>
<td>► Anesthesiologist</td>
</tr>
<tr>
<td>► Radiologist</td>
</tr>
<tr>
<td>► Pathologist</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternity Care &amp; Other Reproductive Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physician’s office:</td>
</tr>
<tr>
<td>Global care (includes pre-and post-natal, delivery) –</td>
</tr>
<tr>
<td>• Physician</td>
</tr>
<tr>
<td>• Midwife (Precertification required)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Hospital / Birthing Center Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Precertification required)</td>
</tr>
<tr>
<td>• Physician’s services</td>
</tr>
<tr>
<td>• Newborn nursery services (well baby care)</td>
</tr>
<tr>
<td>• Circumcision</td>
</tr>
</tbody>
</table>

**Note:** Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified.

<table>
<thead>
<tr>
<th>Infertility Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Covered for services to diagnose infertility only, treatment of infertility is not covered.</td>
</tr>
<tr>
<td>• Treatment for underlying medical conditions are covered as medical.</td>
</tr>
</tbody>
</table>

**Diagnostic Services and Limited Treatment**

**Non-covered Services include** but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.) 20%
### Schedule of Benefits

<table>
<thead>
<tr>
<th>Sterilization Services (Precertification required for Inpatient procedures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section in Covered Services for further details.</td>
</tr>
<tr>
<td>• Vasectomy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Supplies and Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical Supplies</td>
</tr>
<tr>
<td>• Durable Medical Equipment</td>
</tr>
<tr>
<td>• Orthotics</td>
</tr>
<tr>
<td>Foot and Shoe</td>
</tr>
<tr>
<td>• Prosthetic Appliances (external)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutritional Counseling for Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Hospital / Facility Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outpatient facility</td>
</tr>
<tr>
<td>• Lab and x-ray services (non-routine)</td>
</tr>
<tr>
<td>• Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Services (Home and Office Visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ball State Employee Quick Clinic</td>
</tr>
<tr>
<td>Office Surgery</td>
</tr>
<tr>
<td>Online Visits</td>
</tr>
<tr>
<td>Prescription Injectable Drugs / Prescription Drugs Dispensed in the Physician’s Office</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preventive Services (regardless of Provider or setting where preventive care is provided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered at 100%</td>
</tr>
</tbody>
</table>

**Note:** Preventive Services are defined as any claim submitted with a “well” diagnosis.

<table>
<thead>
<tr>
<th>Skilled Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>20%</td>
</tr>
</tbody>
</table>
### Schedule of Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgical Services</strong></td>
<td>20%</td>
</tr>
<tr>
<td>- Gastric Bypass / Obesity Surgery</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Therapy Services (Outpatient)</strong></td>
<td>20%</td>
</tr>
<tr>
<td>- Physical Therapy</td>
<td>20%</td>
</tr>
<tr>
<td>- Occupational Therapy</td>
<td>20%</td>
</tr>
<tr>
<td>- Speech Therapy</td>
<td>20%</td>
</tr>
<tr>
<td>- Cardiac Rehabilitation</td>
<td>20%</td>
</tr>
<tr>
<td>- Chiropractic Care</td>
<td>20%</td>
</tr>
<tr>
<td>- Radiation Therapy</td>
<td>20%</td>
</tr>
<tr>
<td>- Chemotherapy</td>
<td>20%</td>
</tr>
<tr>
<td>- Respiratory Therapy</td>
<td>20%</td>
</tr>
<tr>
<td>- Vision Therapy</td>
<td>20%</td>
</tr>
</tbody>
</table>

**Note:** Inpatient therapy services will be paid under the Inpatient Hospital benefit.

### Benefits

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transplants</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Live Donor Health Services</strong></td>
<td>20%</td>
</tr>
<tr>
<td>- Medically Necessary charges for the procurement of an organ from a live donor are covered up to Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.</td>
<td></td>
</tr>
<tr>
<td><strong>Bone Marrow Donor Search Fee</strong></td>
<td>20%</td>
</tr>
<tr>
<td>- $10,000 per transplant</td>
<td></td>
</tr>
<tr>
<td><strong>Organ Transplants (institutional)</strong></td>
<td>20%</td>
</tr>
<tr>
<td>- Donor expenses are covered.</td>
<td></td>
</tr>
<tr>
<td><strong>Organ Transplants (professional)</strong></td>
<td>20%</td>
</tr>
<tr>
<td>- Donor expenses are covered.</td>
<td></td>
</tr>
<tr>
<td><strong>Travel and Lodging for Organ Transplants</strong></td>
<td>20%</td>
</tr>
<tr>
<td>- Lodging Allowance: $150 per day for double occupancy. If recipient and/or the donor is under age 18 at the time of the transplant procedure, transportation, lodging, and meals for two individuals accompanying the recipient and/or the donor are covered charges, up to a total benefit of $150 per day for lodging meals.</td>
<td></td>
</tr>
<tr>
<td>- Maximum $2500 per transplant</td>
<td></td>
</tr>
</tbody>
</table>
RETIREE ELIGIBILITY AND ENROLLMENT

Retiree Coverage
If You are both an Eligible Retiree and

- Your last date of hire precedes September 1, 1999, You may elect to continue coverage under the Plan if You are enrolled in the Plan at the time of Your retirement and have been so enrolled for at least one year or You pay the equivalent of that year's premium.

- Your last date of hire is on or after September 1, 1999, You may elect to continue coverage under the Plan if You have been enrolled in the Plan at least 15 years and are enrolled at the time of Your retirement.

Effective Date of Coverage
Coverage for Eligible Retirees and their Dependents, if elected, will begin the date immediately following the last day of coverage as an Eligible Employee. Coverage for Surviving Spouses and their Dependents, if elected, will begin immediately following the date of the Eligible Retiree's death.

If an Eligible Retiree, Surviving Spouse or Spouse is a Covered Person under the Plan prior to attaining age 65, coverage under the 65 and Over Retiree Health Plan option under the Plan is automatic when the Eligible Retiree, Surviving Spouse or Spouse attains age 65, and shall begin the 1st of the month of Your 65th birthday; provided, however, if Your birthday falls on the 1st of the month, coverage will begin the first of the prior month.

The effective date of coverage rules are the same for participants who obtain Medicare coverage because of a disability.

Dependents
If an Eligible Retiree is covered by this Plan, he or she may enroll his or her eligible Dependents who are covered under the Plan at the time of the Eligible Retiree's retirement; provided, however, that unless the Dependent is entitled to Medicare Parts A and B, the Dependent must enroll in an option other than the Over 65 Retiree Health Plan option. An Eligible Retiree cannot add a Spouse or Dependent Children to coverage after retirement. An Eligible Retiree's domestic partner is not eligible for retiree coverage.

Surviving Spouse and Dependent Child Coverage
If an Eligible Retiree dies while a Covered Person, and his or her Surviving Spouse and/or Dependent Children are covered under the Plan at the time of the Eligible Employee's death, the Surviving Spouse and/or Dependent Children continue to be eligible to participate in the Plan. Coverage for the Surviving Spouse and Dependent Children will terminate at the end of the month in which the Surviving Spouse remarries.

Election Between Medical Coverage and Coverage under COBRA
An Eligible Retiree or Surviving Spouse must elect between:

- Retiree coverage as provided under this Section, at a cost to the Eligible Retiree or Surviving Spouse and his or her Dependents which will be communicated to the Eligible Retiree or Surviving Spouse; or

- Continuation of coverage under COBRA.

Any coverage that the Eligible Retiree or Surviving Spouse and his or her Dependents elect under the Plan will be in lieu of any COBRA coverage which the Eligible Retiree or Surviving Spouse and his or her Dependents may otherwise be entitled to. If the Eligible Retiree or Surviving Spouse and his or her Dependents elect coverage under COBRA, the Eligible Retiree or Surviving Spouse and his or her
Dependents will be entitled to continue coverage for the time period provided under COBRA. Thereafter, the Eligible Employee or Surviving Spouse and his or her Dependents will not be entitled to any additional coverage set forth in the Plan, except as otherwise required under COBRA.

The Eligible Retiree and his or her Dependents must elect retiree coverage under the Plan on or before the Eligible Employee's retirement. The Eligible Retiree and his or her Dependents must elect COBRA continuation coverage within 60 days after the later of the date:

- the Eligible Retiree would lose coverage due to retirement; or
- the Eligible Retiree and his or her Dependents are sent an election form from Payroll & Employee Benefits.

The Surviving Spouse and his or her Dependents must elect between retiree coverage under the Plan and COBRA continuation coverage within 60 days after the later of the Date:

- the Surviving Spouse would lose coverage due to the Eligible Retiree's death; or
- the Surviving Spouse and his or her Dependents are sent an election form from Payroll & Employee Benefits.

If the Eligible Retiree or Surviving Spouse and his or her Dependents do not timely elect retiree coverage under the Plan, the Eligible Retiree or Surviving Spouse and his or her Dependents will no longer be eligible for coverage under the Plan (except as provided through COBRA, if timely elected).

**Annual Open Enrollment**

Eligible Retiree or Surviving Spouse cannot add new Dependents to coverage after retirement (or after the Eligible Retiree's death) and if a Dependent is dropped from retiree coverage, he or she cannot be added back to coverage. An Eligible Retiree's or Surviving Spouse's failure to make a timely election during the annual open enrollment period will result in a reelection of the then same coverage for benefits, if any, as in effect for the current calendar year. The Retiree Over 65 Health Plan option is the only option available to an Eligible Retiree or Surviving Spouse who has attained age 65. The Retiree Under 65 High Deductible Wellness Plan option is the only option available to an Eligible Retiree or Surviving Spouse who is under the age of 65.

**Change in Status**

Eligible Retirees and Surviving Spouses are required to notify Payroll & Employee Benefits, in writing, of the following changes in status within 31 days of such changes:

- any change in address;
- loss of a Spouse or Dependent Child;
- eligibility for or entitlement to Medicare by the Eligible Retiree or his or her Dependents;
- legal separation or divorce from a Spouse;
- remarriage of a Surviving Spouse;
- a Child ceasing to be a Dependent under the Plan.

The failure to notify Payroll & Employee Benefits of any change described above will be deemed by the University to be an act that constitutes fraud and an intentional misrepresentation of material fact prohibited by the Plan that may result in a retroactive termination of coverage.
Amendment or Termination of Retiree Coverage
The University has the right, in its sole discretion, to amend, modify or terminate retiree coverage under the Plan, including the Eligible Retiree or Surviving Spouse share of the cost of the retiree coverage, at any time and from time to time and to any extent it may deem advisable. No Eligible Retiree, Surviving Spouse or Dependent is vested in any retiree coverage under the Plan.
HOW YOUR PLAN WORKS

Note: Capitalized terms such as Covered Services, Medical Necessity, and Out-of-Pocket Maximum are defined in the “Definitions” Section.

Introduction
The Under 65 Retiree options under the Plan are Preferred Provider Organizations (PPO) which are comprehensive plans. These options are divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

Providers are compensated using a variety of payment arrangements, including fee for service, per diem, discounted fees, and global reimbursement.

All Covered Services must be Medically Necessary, and coverage or certification of services that are not Medically Necessary may be denied.

Network Services
When You use a Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the Network level. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. The Plan has the final authority to decide the Medical Necessity of the service.

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

To see a Doctor, call their office:

• Tell them You are an Anthem Member.
• Have Your Member Identification Card handy. The Doctor’s office may ask You for Your group or Member ID number.
• Tell them the reason for Your visit.

When You go to the office, be sure to bring Your Member Identification Card with You.

For services from Network Providers:

1. You will not need to file claims. 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 Network Provider(s) for any Non-Covered Services You get or when You have not followed the terms of this Benefit Booklet.
2. Precertification will be done by the Network Provider. (See the Health Care Management – Precertification section for further details.)

Please read the Error! Reference source not found. section for additional information on Authorized Services.

After Hours Care
If You need care after normal business hours, Your doctor may have several options for You. You should call Your doctor’s office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency Room.
Out-of-Network Services
When you do not use a Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Booklet.

For services from an Out-of-Network Provider:

- the Out-of-Network Provider can charge you the difference between their bill and the Plan’s Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
- 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. (Please see Health Care Management – Precertification for more details.)

How to Find a Provider in the Network
There are three ways you can find out if a Provider or facility is in the Network for this Plan. You can also find out where they are located and details about their license or training.

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

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

The BlueCard Program
Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called “BlueCard.” This program lets you get Covered Services at the Network cost-share when you are traveling out of state and need health care, as long as you use a BlueCard Provider. All you have to do is show your Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to the Claims Administrator.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

In a non-Emergency situation, you can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Identification Card.

You can also access Physicians and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Please refer to Inter-Plan Programs in the Claims Payment section for more information on BlueCard.

Care Outside the United States – BlueCard® Worldwide
Prior to travel outside the United States, check with Payroll & Employee Benefits or call Customer Service at the number on your Identification Card to find out if the Plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and we recommend:

- Before you leave home, call the Customer Service number on your Identification Card for coverage details.
Always carry your current Identification Card.
In an emergency, go directly to the nearest Hospital.
The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:
- You need to find a Physician or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.
- You need to be hospitalized or need Inpatient care. After calling the Service Center, You must also call the Claims Administrator to obtain approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information
- Participating BlueCard Worldwide Hospitals. In most cases, when You make arrangements for hospitalization through BlueCard Worldwide, You should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the Out-of-Pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) You normally pay. The Hospital should submit Your claim on Your behalf.
- Doctors and/or non-participating Hospitals. You will need to pay upfront for Outpatient services, care received from a Physician, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then You can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing
- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged Your hospitalization. You will need to pay the Hospital for the Out-of-Pocket costs You normally pay.
- You must file the claim for Outpatient and Physician care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to the Claims Administrator.

Claim Forms
International claim forms are available from the Claims Administrator, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is on the form.
HEALTH CARE MANAGEMENT - PRECERTIFICATION

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

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

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

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, You, Your authorized representative or Physician must notify the Claims Administrator within 2 business days after the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

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

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

Failure to Obtain Precertification Penalty:

IMPORTANT NOTE: IF YOU OR YOUR PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, A $300 PENALTY WILL APPLY AND YOUR OUT-OF-POCKET COSTS WILL INCREASE.

The following list is not all inclusive and is subject to change; please call the Customer Service telephone number on Your Identification Card to confirm the most current list and requirements for the Plan.
Inpatient Admission:
- All acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehabilitation, and Obstetrical delivery stays beyond the 48/96 hour Federal mandate length of stay minimum (including newborn stays beyond the mother’s stay)
- Emergency Admissions (requires Plan notification no later than 2 business days after admission)

Outpatient Services:
- Ablative Techniques as a Treatment for Barrett’s Esophagus
- Air Ambulance (excludes 911 initiated emergency transport)
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bone-Anchored Hearing Aids
- Breast Procedures; including Reconstructive Surgery, Implants, Reduction, Mastectomy for Gynecomastia and other Breast Procedures
- Canaloplasty
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Cryoablation for Plantar Fasciitis and Plantar Fibroma
- Cryopreservation of Oocytes or Ovarian Tissue
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain Stimulation
- Diagnostic Testing
  - Diagnosis of Sleep Disorders
- DME/Prosthetics
  - Bone Growth Stimulator: Electrical or Ultrasound
  - Communication Assisting / Speech Generating Devices
  - External (Portable) Continuous Insulin Infusion Pump
  - Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
  - Microprocessor Controlled Lower Limb Prosthesis
  - Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
  - Pneumatic Pressure Device with Calibrated Pressure
  - Power Wheeled Mobility Devices
  - Prosthetics: Electronic or externally powered and select other prosthetics
  - Standing Frame
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Gastric Electrical Stimulation
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Genetic Testing for Cancer Susceptibility
- Implantable or Wearable Cardioverter-Defibrillator
• Implantable Infusion Pumps
• Implantable Middle Ear Hearing Aids
• Implantable Devices for Spinal Stenosis
• Implantable Spinal Cord Stimulators
• Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
• Locally Ablative Techniques for Treating Primary and Metastatic Liver Malignancies
• Lumbar spinal surgeries
• Lung Volume Reduction Surgery
• Lysis of Epidural Adhesions
• Manipulation Under Anesthesia of the Spine and Joints other than the Knee
• Maze Procedure
• MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
• Oral, Pharyngeal & Maxillofacial Surgical Treatment for Obstructive Sleep Apnea
• Occipital nerve stimulation
• Orthognathic Surgery
• Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
• Partial Left Venticulectomy
• Penile Prosthesis Implantation
• Percutaneous Neurolysis for Chronic Back Pain
• Percutaneous Spinal Procedures
• Photocoagulation of Macular Drusen
• Physician Attendance and Supervision of Hyperbaric Oxygen Therapy
• Plastic/Reconstructive surgeries:
  ► Abdominoplasty, Panniculectomy, Diastasis Recti Repair
  ► Blepharoplasty
  ► Brachioplasty
  ► Buttock/Thigh Lift
  ► Chin Implant, Mentoplasty, Osteoplasty Mandible
  ► Insertion/Injection of Prosthetic Material Collagen Implants
  ► Liposuction/Lipectomy
  ► Procedures Performed on Male or Female Genitalia
  ► Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
  ► Procedures Performed on the Trunk and Groin
  ► Repair of Pectus Excavatum / Carinatum
  ► Rhinoplasty
  ► Skin-Related Procedures
• Presbyopia and Astigmatism-Correcting Intraocular Lenses
• Private Duty Nursing
• Radiation therapy
  ► Intensity Modulated Radiation Therapy (IMRT)
  ► Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Surgical Treatment of Migraine Headaches
- Thoracoscopy for Treatment of Hyperhidrosis
- Tonsillectomy in Children
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transmyocardial Preventricular Device
- Transtympanic Micropressure for the Treatment of Ménière’s Disease
- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Varicose Vein Treatment

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

**Out of Network Referrals:**
Out of Network Services for consideration of payment at Network benefit level (may be authorized, based on Network availability and/or Medical Necessity.)

**Mental Health/Substance Abuse:**

**Pre-certification Required**
- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Care
- ABA- Applied Behavioral Analysis
The following services do not require precertification, but are recommended for pre-determination of Medical Necessity due to the existence of post service claim review criteria and/or the potential cost of services to the Member if denied by for lack of Medical Necessity: Procedures, equipment, and/or specialty infusion drugs which have Medically Necessary criteria determined by the Claims Administrator’s Medical Policy or Clinical Guidelines.

Referrals with respect to Under 65 Retiree options:

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

Utilizing a Provider outside of the Network may result in significant additional financial responsibility for You, because the Plan cannot prohibit Out-of-Network Providers from billing You for the difference between the Provider’s charge and the benefit the Plan provides.

The ordering Provider, facility or attending Physician should contact the Claims Administrator to request a Precertification or Predetermination review (“requesting Provider”). The 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.

<table>
<thead>
<tr>
<th>Who is responsible for Precertification?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services provided by a Network Provider, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator’s parent company.</td>
</tr>
<tr>
<td>Provider is responsible for Precertification.</td>
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</tbody>
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The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventive care clinical coverage guidelines, to assist in making Medical Necessity decisions. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically. The Benefits Booklet takes precedence over these guidelines.

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

The Claims Administrator may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in the Claims Administrator’s discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.
In addition, the Claims Administrator may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt Your claim from medical review if certain conditions apply.

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

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

**Request Categories:**

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

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

- **Concurrent** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

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

**Decision and Notification Requirements**

These reviews are subject to the same claims review time frames that are provided in the section Your Right to Appeal. Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on Your Identification Card for additional information.

<table>
<thead>
<tr>
<th>Request Category</th>
<th>Timeframe Requirement for Decision and Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prospective Urgent</td>
<td>72 hours from the receipt of request</td>
</tr>
<tr>
<td>Prospective Non-Urgent</td>
<td>15 calendar days from the receipt of the request</td>
</tr>
<tr>
<td>Concurrent when hospitalized at time of request</td>
<td>72 hours from request and prior to expiration of current certification</td>
</tr>
<tr>
<td>Other Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization</td>
<td>24 hours from the receipt of the request</td>
</tr>
<tr>
<td>Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists</td>
<td>72 hours from the receipt of the request</td>
</tr>
<tr>
<td>Concurrent Non-Urgent for ongoing outpatient treatment</td>
<td>15 calendar days from the receipt of the request</td>
</tr>
<tr>
<td>Retrospective</td>
<td>30 calendar days from the receipt of the request</td>
</tr>
</tbody>
</table>

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

Notification may be given by the following methods:

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

**Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the Covered Person or authorized Covered Person’s representative.

**Precertification does not guarantee coverage for or payment of the service or procedure reviewed.**

**For benefits to be paid, on the date You receive service:**

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

**Individual Case Management**

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

The Claims Administrator’s Case Management programs are confidential and voluntary. These programs are given at no extra cost to you.

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

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

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

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details. All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.

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

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

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

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

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

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

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

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

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.**

Assistant Surgery
Services rendered by an assistant surgeon are covered based on Medical Necessity.

Behavioral Health Care and Substance Abuse Treatment
See the Schedule of Benefits for any applicable Deductible, Coinsurance, or Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or Outpatient basis will not be subject to Deductibles, Copayment, or Coinsurance provisions that are less favorable than the Deductibles, Copayment, or Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Hospital Inpatient Care
Benefits for Inpatient Hospital and Physician charges are Covered Services.

Professional Outpatient Care
Covered Services include:
- Professional care in the Outpatient department of a Hospital;
- Physician's office visits; and
- Services within the lawful scope of practice of a licensed, approved provider.

**Note:** To be reimbursable, care must be given by a psychiatrist, psychologist, neuropsychologist, or a mid-level provider such as a licensed clinical social worker, mental health clinical nurse specialist, a marriage and family therapist, or a licensed professional counselor.

Breast Cancer Care
Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Covered Person. Follow-up visits are also included and may be conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Covered Person.

Breast Reconstructive Surgery
Covered Services are provided following a 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.

Cardiac Rehabilitation
Covered Services are provided as outlined in the Schedule of Benefits.

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

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

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

The Plan may require You to use a Network Provider to maximize your benefits.

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

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Experimental/Investigative as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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

i. The Experimental/Investigative item, device, or service, itself; or
ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.
Routine patient costs in connection with an approved clinical trial include all items and services consistent with the coverage provided in the Plan that is typically covered for a Covered Person who is not enrolled in an approved clinical trial. Routine patient costs do not include: the investigational item, device or service itself; items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

To be eligible for coverage of routine patient costs in connection with an approved clinical trial, (i) the Covered Person must be eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and (ii) either (A) the referring health care professional is a participating health care provider and has concluded that the Covered Person's participation in the approved clinical trial would be appropriate based upon the Covered Person meeting the conditions under (i) or (B) the Covered Person provides medical and scientific information establishing that the Covered Person's participation in the approved clinical trial would be appropriate based upon the Covered Person meeting the conditions under (i).

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. Second surgical opinion consultations are covered.

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.

Dental Services

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

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

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

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

Diabetes
Equipment and Outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for Outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under “Preventive Care.”
Dialysis Treatment
The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Covered Person has not applied for eligible coverage available through Medicare.

Durable Medical Equipment
This Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Covered Person’s medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:
- It can stand repeated use;
- It is manufactured solely to serve a medical purpose;
- It is not merely for comfort or convenience;
- It is normally not useful to a person not ill or Injured;
- It is ordered by a Physician;
- The Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item;
- It is related to the Covered Person’s physical disorder.

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

Coverage is provided for Hospital emergency room care including a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Medical Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan.

Stabilize means, with respect to an Emergency Medical Condition: to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term “stabilize” also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

The Maximum Allowed Amount for emergency care from an Out-of-Network Provider will be the greatest of the following:
- The amount negotiated with Network Providers for the Emergency Service furnished;
- The amount for the Emergency Service calculated using the same method the Claims Administrator generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network (if applicable) is shown in the Schedule of Benefits.
**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.

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 anesthesiologist.

**Habilitative Services**
Benefits also include 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.

**Home Health Care Services**
Home Health Care provides a program for the Covered Person's care and treatment in the home. Your coverage is outlined in the Schedule of Benefits. 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 Covered Person’s attending Physician. Services may be performed by either Network or Out-of-Network Providers.

Some special conditions apply:
- The Physician’s statement and recommended program must be precertified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce Outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Covered Person must be essentially confined at home.

**Covered Services:**
- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Covered Person.
- 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 Covered Person to understand the emotional, social, and environmental factors resulting from or affecting the Covered Person’s illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

**Covered Services for Home Health Care do not include:**
- Food, housing, homemaker services, sitters, home-delivered meals.
- Home Health Care services which are not Medically Necessary or 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 Covered Person’s home or is a member of the family of either the Covered Person or Covered Person’s Spouse.
- Any services for any period during which the Covered Person is not under the continuing care of a Physician.
• Convalescent or Custodial Care where the Covered Person 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 Covered Person.
• Any services or supplies not specifically listed as Covered Services.
• Routine care and/or examination of a newborn child.
• Dietician services.
• Maintenance therapy.
• Dialysis treatment.
• Purchase or rental of dialysis equipment.

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

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

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

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

Hospital Services
For Under 65 Retiree options, You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. The Plan provides Covered Services when the following services are Medically Necessary.

Network or Over 65 Retiree Option
Inpatient Services
• Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital’s prevalent Semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital’s prevalent room rate.
Service and Supplies
- Services and supplies provided and billed by the Hospital while You are an Inpatient, 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, record, tape or CD players, telephones, visitors’ meals, etc.) will not be covered.

Length of Stay
- Determined by Medical Necessity.

Out-of-Network Hospital Benefits
If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the Schedule of Benefits.

Hospital Visits
The Physician’s visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

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

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

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

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

Prior Approval and Precertification
In order to maximize Your benefits, the Claims Administrator strongly encourages You to call its’ transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Claims Administrator’s Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.
Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging
The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your covered transplant procedure will be performed. The Plan’s assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Covered Person and one companion for an adult Covered Person, or two companions for a child patient. The Covered Person must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Licensed Speech Therapist Services
Services must be ordered and supervised by a Physician as outlined in the Schedule of Benefits. Speech Therapy is not covered when rendered for the treatment of Developmental Delay.

Maternity Care and Reproductive Health Services
Covered Services are provided for Network Maternity Care subject to the cost share 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.

Routine newborn nursery care is part of the mother’s maternity benefits. Benefits are provided for well baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See “Changing Coverage (Adding a Dependent)” to add a newborn to Your coverage.)

Under federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Covered Person’s attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Covered Person will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician’s office or in the Covered Person’s home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of provider rendering the service will be made by the Covered Person’s attending Physician.

Abortion (Therapeutic or Elective) - The Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape. The Plan also provides benefits for an elective (voluntary) abortion, which is an abortion performed for reasons other than those described above.

Contraceptive Benefits
Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details. Infertility Services
The Plan also includes benefits for the diagnosis and treatment of infertility. Covered Services include diagnostic and exploratory procedures to determine whether a Covered Person suffers from infertility. This includes surgical procedures to correct any diagnosed disease or conditions affecting the reproductive organs; however, this does not include in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization. See the Schedule of Benefits for benefit limitations, and Coinsurance and Copayment amounts.

**Sterilization Services**
Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the “Preventive Care” benefit.

**Medical Care**
General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

**Nutritional Counseling**
Nutritional counseling related to the medical management of a disease state as stated in the Schedule of Benefits.

**Obesity**
Prescription Drugs and any other services or supplies for the treatment of obesity are not covered.

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

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the “Dental Services” section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

**Other Covered Services**
The Plan provides Covered Services when the following services are Medically Necessary:
- Chemotherapy and radioisotope, radiation and nuclear medicine therapy
- Diagnostic x-ray and laboratory procedures
- Dressings, splints, casts when provided by a Physician
• Oxygen, blood and components, and administration
• Pacemakers and electrodes
• Use of operating and treatment rooms and equipment

Out-of-Network Freestanding Ambulatory Facility
Any services rendered or supplies provided while You are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

Out-of-Network Hospital Benefits
If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the Schedule of Benefits.

Outpatient CT Scans and MRIs
These services are covered at regular Plan benefits.

Outpatient Surgery
Network Hospital Outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. These benefits are subject to both Deductible and percentage payable (Coinsurance) requirements. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services.”

Physical Therapy, Occupational Therapy, Chiropractic Care
Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the Schedule of Benefits. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual provider. No coverage is available when such services are necessitated by Developmental Delay.

Physician Services
You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements.

Preventive Care
Preventive Care services include Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

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

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

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force.
   Examples of these services are screenings for:
   a. Breast cancer;
   b. Cervical cancer;
   c. Colorectal cancer;
   d. High Blood Pressure;
   e. Type 2 Diabetes Mellitus;
f. Cholesterol;
g. Child and Adult Obesity.

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

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

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
   a. Women’s contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
   b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
   c. Gestational diabetes screening.

5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
   a. Counseling;
   b. Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

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


Prosthetic Appliances
Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries; electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

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

Reconstructive surgery is covered only to the extent Medically Necessary:
• to correct significant anatomic deformities which are not within normal anatomic variation and which are caused by congenital or developmental abnormalities, illness, or Injury for the purpose of improving the significant anatomic deformity toward a normal appearance; or
• to correct medical complications or post-surgical deformity, unless the previous surgery was not a Covered Service.

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

**Retail Health Clinic**
Medical benefits are provided for Covered Services received at a Retail Health Clinic. Please note that Walgreens is not in the Plan’s retail pharmacy network for prescription coverage for the High Deductible Wellness PPO Plan.

**Skilled Nursing Facility Care**
Benefits are provided as outlined in the **Schedule of Benefits**. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be precertified. Claims will be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:
• a favorable prognosis;
• a reasonably predictable recovery time; and
• services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Covered Person’s residence.

Covered Services include:
• semiprivate or ward room charges including general nursing service, meals, and special diets. If a Covered Person stays in a private room, this Plan pays the Semiprivate room rate toward the charge for the private room;
• use of special care rooms;
• pathology and radiology;
• physical or speech therapy;
• oxygen and other gas therapy;
• drugs and solutions used while a patient;
• gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician’s continuous care and 24-hour-a-day nursing care.

Benefits will not be provided when:
• A Covered Person reaches the maximum level of recovery possible and no longer requires other than routine care;
• Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
• Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
• A Covered Person is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
• The care rendered is for other than Skilled Convalescent Care.

**Surgical Care**
Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

**Treatment of Accidental Injury in a Physician’s Office**
All Outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician’s office, will be covered under the Covered Person’s Physician’s office benefit and are subject to Deductible and Coinsurance requirements.
LIMITATIONS AND EXCLUSIONS

1. **Admissions for Non-Inpatient Services** - Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.

2. **Administrative Charges** - Charges for any of the following:
   a. Failure to keep a scheduled visit;
   b. Completion of claim forms or medical records or reports unless otherwise required by law;
   c. For Physician or Hospital's stand-by services;
   d. For holiday or overtime rates.
   e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
   f. Specific medical reports including those not directly related to the treatment of the Covered Person, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

3. **Allergy Services** - 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.

4. **Alternative Therapies** - Hypnotherapy, acupuncture and acupuncture therapy. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy at a salon, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris. This exclusion also applies to recreational, or educational sleep therapy or other forms of self-care or non medical self-help training and any related diagnostic testing.

5. **Before Coverage Begins / After Coverage Ends** - Services rendered or supplies provided before coverage begins or after coverage ends.

6. **Biomicroscopy** - Biomicroscopy, field charting or aniseikonic investigation.

7. **Comfort and Convenience Items** - 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.

8. **Complications** - Complications of non-covered procedures are not covered.

9. **Cosmetic Services / 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. 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 by the Claims Administrator is not covered. (See sections a. and b. below.)
   a. This exclusion does not apply to surgery to restore function if any body area 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 that caused 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.
   b. This exclusion does not apply to Breast Reconstructive Surgery.
Complications directly related to cosmetic services treatment or surgery, as determined by the Claims Administrator, are not covered. {This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Covered Person was covered by another carrier / self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including, but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.}

10. **Court-Ordered Services** - Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.

11. **Crime and Incarceration** - Injuries received while committing a crime as well as care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation. This Exclusion does not apply if you were the victim of a crime, including domestic violence.

12. **Custodial Care and Rest Care** - Custodial care, domiciliary care, rest cures, or travel expenses 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.

13. **Daily Room Charges** - Daily room charges while the Plan is paying for an Intensive care, cardiac care, or other special care unit.

14. **Dental Care** - 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; 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. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.

15. **Educational Services** - Educational services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, learning disorders, behavioral training, and cognitive rehabilitation.. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Plan provides for neurological disorders and applied behavioral analysis), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning disabilities, behavioral problems, and mental and intellectual disability. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered.


17. **Employer or Association Medical / Dental Department** - Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

18. **Experimental / Investigative Services** - Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator’s judgment, Experimental or Investigative for the diagnosis for which the Covered Person is being treated. An Experimental or Investigative service is not made eligible for coverage by the fact that other treatment is considered by a Covered Person’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.

19. **Family Members** - Services rendered by a Provider who is a close relative or member of Your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.
20. **Foot Care** - Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Covered Persons with impaired circulation to the lower extremities.

21. **Free Services** - 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.

22. **Government Programs** - Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Covered Person 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.

23. **Health Spa** - Expenses incurred at a health spa or similar facility.

24. **Hearing Aids** - Hearing aids, hearing devices or examinations for prescribing or fitting them.

25. **Ineligible Hospital** - Any services rendered or supplies provided while You are confined in an Ineligible Hospital.

26. **Ineligible Provider** - Any services rendered or supplies provided while You are a patient or receive services at or from an Ineligible Provider.

27. **Infertility Services** - For artificial insemination; fertilization (such as in vitro or GIFT) or procedures and testing related to fertilization; infertility drugs and related services following the diagnosis of infertility.

28. **Inpatient Rehabilitation Programs** - Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Covered Person is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
   a. the treatment is for maintenance therapy; or
   b. the Covered Person has no restorative potential; or
   c. the treatment is for congenital learning or neurological disability/disorder; or
   d. the treatment is for communication training, educational training or vocational training.

29. **Maintenance Care** - Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, Injury or condition which is resolved or stable.

30. **Marital Counseling** - Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

31. **Medicare Benefits** - Services paid under Medicare or which would have been paid if the Covered Person had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payor whether or not the Covered Person has enrolled Medicare Part B. For services provided pursuant to a private contract between the Covered Person and a Provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
32. **Never Events** – The Plan will not pay for errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care facility. The Provider will be expected to absorb such costs. This Exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.

33. **Non-Covered Services** - Any item, service, supply or care not specifically listed as a Covered Service in this Benefit Booklet.

34. **Not Medically Necessary Services** - Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

35. **Obesity Services** - 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. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric care, or counseling. Weight loss programs included but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include, but are not limited to, specific bariatric services and surgeries (e.g., liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw).

36. **Obesity Surgery** - For bariatric surgery, regardless of the purpose it is proposed or performed for. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by the Claims Administrator, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous plan, and it applies if the surgery was performed while the Covered Person was covered by a previous carrier/self-funded plan prior to coverage under this Plan. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

37. **Over the Counter Drug Equivalents** - Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply—This Exclusion does not apply to over-the-counter products that the Plan must cover as a “Preventive Care” benefit under Federal law with a Prescription.

38. **Prescription Drugs** - Any Prescription Drugs purchased at a retail or Home Delivery (Mail Service) Pharmacy. Drug coverage is provided by Express Scripts, Inc.

39. **Private Duty Nursing** – For Private Duty Nursing services except when provided through the “Home Care” benefit.

40. **Private Rooms** - Private room, except as specified as Covered Services.

41. **Research Screenings** – For examinations related to research screenings, unless required by law.

42. **Reversal of Sterilization** - Services related to or performed in conjunction with reverse sterilization.
43. **Routine Examinations** - Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms illness or Injury except those which may be specifically listed as covered in this Benefit Booklet.

44. **Safe Surroundings** - Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.

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

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

47. **Sexual Dysfunction** - Medical/ surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction) regardless of origin or cause. This exclusion also includes penile prostheses or Implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

48. **Sexual Transformation** - Surgical care or medical treatment or study related to the modification of sex (transsexualism) and related services, or the reversal thereof.

49. **Shoes and Orthotics** - Shoe inserts, orthotics (except when prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).

50. **Smoking Cessation** – Smoking Cessation programs and treatment of nicotine addiction including gum, patches and Prescription Drugs to eliminate or reduce dependency on, or addiction to tobacco and tobacco products, unless otherwise required by law.

51. **Spider Veins** - Treatment of telangiectatic dermal veins (spider veins) by any method.

52. **Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary** - Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to:
   a. Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards;
   b. Household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs;
   c. The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment;
   d. Water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers;
   e. Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to a Covered Person’s house or place of business and adjustments made to vehicles;
   f. Air conditioners, humidifiers, dehumidifiers, or purifiers;
   g. Rental or purchase of equipment if You are in a facility which provides such equipment;
   h. Other items of equipment that the Claims Administrator determines do not meet the listed criteria.

53. **Therapy Services** - Services for Outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, rolfing, psychodrama, megavitamin
therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, 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.

54. **Transplant Services** - The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
   a. Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
   b. Transportation, travel or lodging expenses for non-donor family members;
   c. Donation related services or supplies, including search, associated with organ acquisition and procurement;
   d. Chemotherapy with autologous, allogenic or syngenetic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered; any transplant not specifically listed as covered.

55. **Transportation** - Transportation provided by other than a state licensed professional ambulance service, and Ambulance Services that are not Medically Necessary. Transportation to another area for medical care is also excluded except as stated as covered under the “Ambulance Service” section. Ambulance transportation from the Hospital to the home is not covered.

56. **Travel Costs and Mileage** - For mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the University.

57. **Thermograms** - Thermograms and thermography.

58. **Vision Care** - Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated in this Benefit Booklet. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.

59. **Vision Surgeries** - Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; 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.

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

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

62. **War / Military Duty** - 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 military service provided or available from the Veterans' Administration or military facilities except as required by law.

63. **Workers’ Compensation** - Care for any condition or Injury recognized or allowed as a compensable loss through any Workers’ Compensation, occupational disease or similar law. If Workers’ Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.
CLAIMS PAYMENT

Providers who participate in the BlueCard® PPO Network have agreed to submit claims directly to the local Blue Cross and/or Blue Shield plan in their area. Therefore if the BlueCard® PPO Network Hospitals, Physicians and Ancillary Providers are used, claims for their services will generally not have to be filed by the Covered Person. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on the Blue Cross and Blue Shield Identification Card is provided to them. If the provider requests a claim form to file a claim, a claim form can be obtained by contacting Payroll & Employee Benefits or by visiting www.anthem.com.

Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign providers from sending Your claims and other personal information to the Claims Administrator.

How to File Claims
Under normal conditions, the Claims Administrator should receive the proper claim form within 12 months after the service was provided. This section of the Benefit Booklet describes when to file a benefits claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan.

When You receive Covered Services from a Network Physician or other Network licensed health care Provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the Provider.

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from the University or the Claims Administrator. Claims 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 Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

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.

Maximum Allowed Amount

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

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

- that meets the Plan’s 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 amount can be significant.

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

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

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

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

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

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

1. An amount based on the Claims Administrator’s Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established in its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

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

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

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

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

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

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

**Covered Person Cost Share**

For certain Covered Services and depending on the Plan, 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 Maximums may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please see the **Schedule of Benefits** in this Benefit Booklet for Your cost share responsibilities and limitations, or call Customer Service to learn how the Plan’s benefits or cost share amounts may vary by the type of Provider You use.

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this Benefit Booklet and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.
In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider’s charge.

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

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

**Processing Your Claim**
You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician’s office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

**Timeliness of Filing for Covered Person Submitted Claims**
To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

**Necessary Information**
In order to process Your claim, the Claims Administrator may need information from the Provider of the service. As a Covered Person, You agree to authorize the Physician, Hospital, or other provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.
Explanation of Benefits
After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;
- the amount for which You are responsible (if any); and
- general information about Your Appeals rights.

Inter-Plan Programs

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

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

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

Whenever You access covered healthcare services outside Anthem’s service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

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

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

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

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, the Claims Administrator would then calculate your liability for any covered healthcare services according to applicable law.
You will be entitled to benefits for healthcare services that you accessed either inside or outside the geographic area Anthem serves, if this Benefit Booklet covers those healthcare services. Due to variations in Host Blue network protocols, you may also be entitled to benefits for some healthcare services obtained outside the geographic area Anthem serves, even though you might not otherwise have been entitled to benefits if you had received those healthcare services inside the geographic area Anthem serves. But in no event will you be entitled to benefits for healthcare services, wherever you received them that are specifically excluded from, or in excess of the limits of, coverage provided by this Plan.

Non-Participating Healthcare Providers Outside Anthem’s Service Area

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

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

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

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

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

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.
The coverage and any benefits under the Plan are not assignable by any Covered Person without the written consent of the Plan, except as provided above.

**Questions About Coverage or Claims**
If You have questions about Your coverage, contact the Plan Administrator or the Claims Administrator’s Customer Service Department. Be sure to always give Your member Identification number.

When asking about a claim, give the following information:
- identification number;
- patient’s name and address;
- date of service and type of service received; and
- provider name and address (Hospital or Physician).

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

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

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

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

Internal Claim Appeals

Initial Review of Claims
When a claim for benefits has been properly filed under the Plan, or when Precertification has been sought (this will be treated as a claim for purposes of this Section), the claimant will be notified of the approval or Denial within the time periods set forth in the chart at the end of this Section. For Urgent Care Claims, the Claims Administrator will defer to the attending provider with respect to the decision as to whether a claim is an "Urgent Care Claim" for purposes of determining the applicable time period. If your claim is denied, you will receive notice in accordance with this Section.

Initial Denial of Claims
If any claim for benefits is partially or wholly denied, the claimant will be given notice which will contain:

1. the specific reasons for the Denial;
2. references to Plan provisions upon which the Denial is based;
3. a description of any additional material or information needed and why such material or information is necessary;
4. a description of the Plan's review procedures and time limits, including information regarding how to initiate an appeal and information on the External Review process;
5. the specific internal rule, guideline, protocol, or other similar criterion, if any, relied upon in making the Denial, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon, with a copy free of charge upon request;
6. if the Denial is based on a Medical Necessity or Experimental/Investigative treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request;
7. information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
8. the Denial code and its corresponding meaning, as well as a description of the Claims Administrator's standard, if any, that was used in the Denial of the claim;
9. the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist individuals with the internal claims and appeals and External Review processes; and
10. for Urgent Care Claims, a description of the expedited review process applicable to such claims. For Urgent Care Claims, the information in the notice may be provided orally if the claimant is given notification within 3 days after the oral notification.

Appeal of Claim Denial
A claimant may appeal the Denial of a claim by filing a written claim appeal with the Claims Administrator or its designee within the time period set forth in the chart at the end of this Section, which will be deemed filed upon receipt. If the request is not timely, the decision of the Claims Administrator shall be the final
decision of the Plan, and will be final, conclusive, and binding on all persons. For Urgent Care Claims, a claimant may make a request for an expedited appeal orally or in writing, and all necessary information will be transmitted by telephone, facsimile, or other similarly expeditious method.

Denial of Appeal
1. The claimant will receive notice of the Claims Administrator’s decision on appeal within the time periods set forth in the chart at the end of this Section. If the claim is denied on appeal, the notice will serve as the Final Denial.

2. The Claims Administrator will provide the following information to the claimant free of charge as soon as possible and sufficiently in advance of the date on which the notice of Final Denial is required, such that the claimant has a reasonable opportunity to respond prior to that date: (i) any new or additional evidence considered, relied upon, or generated by the Claims Administrator (or at the direction of the Claims Administrator) in connection with the claim; and (ii) any new or additional rationale that forms the basis of the Claims Administrator’s Final Denial, if any.

3. If the claim is denied on appeal, the claimant will be given notice which will contain a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant’s claim, as well as items (1), (2), (5), (6), (7), (8), and (9) under the "Initial Denial of Claims" section above, as well as: (i) a description of the review procedures and time limits, including information regarding how to initiate an appeal and information on the External Review process; and (ii) if the Denial is a Final Denial, a discussion of the decision. A decision on review will be final, conclusive, and binding on all persons.

Ongoing Treatments
If the Claims Administrator has approved an ongoing course of treatment to be provided to a claimant over a certain period of time or for a certain number of treatments, any reduction or termination of such course of treatment before the approved period of time or number of treatments end will constitute a Denial. The claimant will be notified of the Denial, in accordance with the "Initial Denial of Claims" section above, before the reduction or termination occurs to allow the claimant a reasonable time to file an appeal and obtain a determination on the appeal. Coverage for the ongoing course of treatment that is the subject of the appeal will continue pending the outcome of such appeal.

For an Urgent Care Claim, any request by a claimant to extend the ongoing treatment beyond the previously approved period of time or number of treatments will be decided and communicated to the claimant as soon as possible but no later than 24 hours after receipt of the Urgent Care Claim, provided the claim is filed at least 24 hours before the treatment expires.

Authorized Representative
The Plan will not prevent an authorized representative of a claimant from acting on behalf of the claimant in pursuing a benefit claim or appeal, pursuant to reasonable procedures. In the case of an Urgent Care Claim, a Health Care Professional with knowledge of a claimant’s medical condition (e.g., the claimant’s Physician) will be permitted to act as the authorized representative of the claimant.

Calculating Time Periods
The period of time within which an initial benefit determination or a determination on an appeal is required to be made will begin when a claim or appeal is filed, regardless of whether the information necessary to make a determination accompanies the filing.

Solely for purposes of initial Pre-Service Claims and Post-Service Claims, if the time period for making the initial benefit determination is extended (in the Claims Administrator’s discretion) because the claimant failed to submit information necessary to decide the claim, the time period for making the determination will be tolled from the date notification of the extension is sent to the claimant until the earlier of (i) the date on which a response from the claimant is received, or (ii) the end of the time period given to the claimant to provide the additional information (at least 45 days).
Full and Fair Review

Upon request and free of charge, the claimant or his or her duly authorized representative will be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim, or may submit to the appropriate person or entity written comments, documents, records, and other information relating to the claim.

If a review is timely requested, such review of a denied claim for benefits will take into account all comments, documents, records, and other information submitted by the claimant or his or her duly authorized representative relating to his or her claim without regard to whether such information was submitted or considered in the initial benefit determination.

Appeals of claims shall be reviewed by the Claims Administrator who is named fiduciary of the Plan and who is neither the individual nor subordinate of the individual who made the initial determination. The Claims Administrator shall not give any weight to the initial determination, and, if the appeal is based, in whole or in part, on a medical judgment, the Claims Administrator shall consult with an appropriate Health Care Professional who is neither the individual nor subordinate of the individual who was consulted in connection with the initial determination. The Claims Administrator shall identify any medical or vocational experts whose advice was obtained without regard to whether the advice was relied upon in making the benefit determination.

Claimants and this Plan may have other voluntary alternative dispute resolution options, such as mediation. For available options, claimants could contact their local U.S. Department of Labor Office and their State insurance regulatory agency.

Exhaustion of Remedies

If a claimant fails to file a request for review of a Denial, in whole or in part, of benefits in accordance with the procedures herein outlined, such claimant will have no right to review and no right to bring action, at law or in equity, in any court, and the Denial of the claim will become final and binding on all persons for all purposes.

Unless the exception in the following paragraph applies, if the Claims Administrator fails to strictly adhere to all the requirements with respect to a claim under this "Internal Appeals" section, the claimant is deemed to have exhausted the internal claims and appeals process with respect to such claims. Accordingly, the claimant may initiate an External Review with respect to such claims, as outlined in below. The claimant also is entitled to pursue any available remedies under State law with respect to such claims.

Notwithstanding the previous paragraph, the internal claims and appeals process will not be deemed exhausted based on \textit{de minimis} violations that do not cause, and are not likely to cause, prejudice or harm to the claimant 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 the Claims Administrator and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the Claims Administrator. The claimant may request a written explanation of the violation from the Claims Administrator, and the Claims Administrator shall provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the process outlined in this "Internal Appeals" section to be deemed exhausted. If the Independent Review Organization ("IRO"), as defined below, or a court rejects the claimant's 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, the claimant shall 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 shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon the claimant's receipt of such notice.
External Review Process

Application and Scope of External Review Process
Subject to the following paragraph, upon receipt of a Final Denial (including a deemed Final Denial), the claimant may apply for External Review as provided in this "External Review Process" section. Upon receipt of a Denial that is not a Final Denial, the claimant may only apply for External Review as provided under subsection regarding expedited External Review for Urgent Care Claims.

With respect to claims for which External Review is initiated before September 20, 2011, the claimant may request External Review for any Final Denial or eligible Denial, except that a Denial, reduction, termination, or failure to provide Payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility based under the terms of the Plan is not eligible for External Review. With respect to claims for which External Review is initiated on or after September 20, 2011, the External Review process will apply only to:

1. a Final Denial or eligible Denial that involves medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigative); and

2. a Rescission of coverage (whether or not the Rescission has any effect on any particular benefit at that time).

Standard External Review Process for Claims
1. Timing of Request for External Review. The claimant must file a request for External Review of a claim with the Claims Administrator no later than the date which is 4 months following the date of receipt of a notice of Final Denial. If there is no corresponding date 4 months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following receipt of the notice (e.g., if a Final Denial is received on October 30, request must be made by the following March 1). If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

2. Preliminary Review. The Claims Administrator shall complete a preliminary review of the request for External Review within 5 business days to determine whether: (i) the claimant is or was covered under the Plan at the time the Covered Medical Service was requested or provided, as applicable; (ii) the type of claim is eligible for External Review; (iii) the claimant has exhausted (or is deemed to have exhausted) the Plan's internal claims and appeals process under the Plan; and (iv) the claimant has provided all the information and forms required to process an External Review. The Claims Administrator will issue a notification to the claimant within 1 business day of completing the preliminary review. If the request is complete, but ineligible for External Review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the claimant shall be allowed to perfect the request for External Review by the later of the 4 month filing period described in paragraph (1) above, or within the 48-hour period following the receipt of the notification.

3. Referral to Independent Review Organization (IRO). The Claims Administrator will assign an IRO to the claimant's request for External Review. Upon assignment, the IRO will undertake the following tasks with respect to the claimant's request for External Review:

   (a) Timely notify the claimant in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that the claimant may submit in writing to the IRO, within 10 business days following the date of receipt of the notice, additional information
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.

(b) Review all documents and any information considered in making a Final Denial received by
the Claims Administrator. The Claims Administrator shall 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 the claimant
and the Claims Administrator of its decision within 1 business day.

(c) Forward any information submitted by the claimant 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 the claimant and IRO within 1 business day,
and the IRO shall then terminate the External Review.

(d) 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 Plan's internal claims
and appeals 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) the claimant's
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, the claimant, or the claimant's 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(s) after considering the information described in
this paragraph to the extent the information or documents are available and the clinical
reviewer(s) consider appropriate.

4. Notice of Final External Review Decision. The IRO will provide written notice of Final External Review
decision within 45 days after the IRO receives the request for External Review. Such notice will be
delivered to the claimant and the Claims Administrator and will contain the following: (i) a general
description of the reason for the request for External Review, including information sufficient to identify
the claim (including the date or dates of service, the health care provider, the claim amount (if applicable),
the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous Denial); (ii) the date the IRO received the
assignment to conduct External Review and the date of the Final External Review Decision; (iii)
references to the evidence or documentation, including specific coverage provisions and evidence-
based standards, considered in reaching the decision; (iv) a discussion of the principal reason or
reasons for its decision, including the rationale for its decision and any evidence-based standards that
were relied upon in making its decision; (v) a statement that the determination is binding except to the
extent that other remedies may be available under State or Federal law to either the Plan or the
claimant; (vi) a statement that judicial review may be available to the claimant; and (vii) current contact
information, including phone number, for any applicable office of health insurance consumer assistance
or ombudsman established under Section 2793 of the Public Health Service Act.
5. *Reversal of Plan's Decision.* If the Final Denial of the Plan is reversed by the Final External Review Decision, the Plan will immediately provide coverage or Payment (including immediately authorizing or immediately paying benefits) for a claim, upon receipt of notice of such reversal.

6. *Maintenance of Records.* The IROs will maintain records of all claims and notices associated with an External Review for 6 years. An IRO must 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.

**Expedited External Review Process**

1. *Application of Expedited External Review.* The Plan will allow the claimant to make a request for expedited External Review at the time the claimant receives either:

   A Denial, if the Denial involves a medical condition of the claimant’s for which the timeframe for completion of an internal appeal of an Urgent Care Claim would seriously jeopardize the claimant’s life or health or would jeopardize the claimant’s ability to regain maximum function and the claimant has filed a request for an appeal of an Urgent Care Claim; or

   A Final Denial, if the claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the claimant’s life or health or would jeopardize the claimant’s ability to regain maximum function, or if the Final Denial concerns admission, availability of care, continued stay, or a health care item or service for which the claimant received Emergency services, but has not been discharged from a facility.

2. *Preliminary Review.* Immediately upon receipt of a request for expedited External Review, the Claims Administrator must determine whether the request meets the reviewability requirements set forth in paragraph (1) above. The Claims Administrator will immediately send a notice that meets the requirements set forth above with respect to the preliminary review for standard External Review of the claimant for its eligibility determination.

3. *Referral to Independent Review Organization (IRO).* Upon a determination that a request is eligible for expedited External Review following the preliminary review, the Claims Administrator will assign an IRO pursuant to the requirements set forth above for standard External Review. The Claims Administrator must provide or transmit all necessary documents and information considered in making the Denial or Final Denial determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard External Review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Claims Administrator’s internal claims and appeals process.

4. *Notice of Final External Review Decision.* The IRO will provide notice of Final External Review Decision, in accordance with the requirements set forth above for standard External Review, as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing such notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Claims Administrator.

**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 Department of Labor 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 the 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 12 shall be provided or applied only if the Plan is required to do so under applicable legal requirements and the U.S. Departments of Labor, Treasury, and Health and Human Services are currently enforcing such requirements. For these purposes, the Plan may rely fully on the U.S. Department of Labor Technical Release 2011-01, the U.S. Department of Labor Technical Release 2011-02, the June 24, 2011 amendment to the interim final regulations published July 23, 2010, and any subsequent guidance.
### Chart of Time Limits for Claims and Internal Appeals

<table>
<thead>
<tr>
<th>MAXIMUM TIME LIMITS FOR:</th>
<th>TYPE OF CLAIM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urgent Care Claims</td>
</tr>
<tr>
<td>Claims Administrator to decide initial claim (if no additional information is needed) (whether adverse or not)</td>
<td>No later than 72 hours after receipt of claim by the Claims Administrator</td>
</tr>
<tr>
<td>Extension of time by Plan for determining initial claim</td>
<td>None</td>
</tr>
<tr>
<td>Claims Administrator to notify claimant of information needed from claimant to decide initial claim, if not provided by claimant</td>
<td>No later than 24 hours after receipt of incomplete claim by Claims Administrator</td>
</tr>
<tr>
<td>Claims Administrator to notify claimant of claimant's failure to follow proper procedures</td>
<td>No later than 24 hours after receipt of improper claim by Claims Administrator</td>
</tr>
<tr>
<td>Claimant to then provide needed information (if extension allowed by Plan)</td>
<td>Not less than 48 hours after receipt of notice from Claims Administrator</td>
</tr>
<tr>
<td>Claims Administrator to decide claim after requesting additional information and notifying claimant (if applicable)</td>
<td>No later than 48 hours after earlier of (i) Claims Administrator's receipt of additional information from claimant, or (ii) end of time period given to claimant to provide additional information (48 hours)</td>
</tr>
<tr>
<td>Claimant to file appeal</td>
<td>180 days after receipt of Denial by claimant</td>
</tr>
<tr>
<td>Claims Administrator to decide appeal</td>
<td>72 hours after Claims Administrator's receipt of appeal from claimant</td>
</tr>
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</table>
COORDINATION OF BENEFITS (COB)

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

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

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

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

COB DEFINITIONS

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

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

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

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

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

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when You have health care coverage under more than one Plan.
When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

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

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because You have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
6. The amount that is subject to the Primary high-deductible health plan's Deductible, if the Claims Administrator has been advised by You that all Plans covering You are high-deductible health plans and You intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

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

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

**ORDER OF BENEFIT DETERMINATION RULES**

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

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
1. Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

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

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

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

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

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

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

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

3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.
Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits.

Rule 4 - COBRA. If You are covered under COBRA or under a right of continuation provided by other federal law and are covered under another Plan, the Plan covering You as an employee, Covered Person, subscriber or retiree or covering You as a Dependent of an employee, Covered Person, subscriber or retiree is the Primary Plan and the COBRA or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if “Rule 1 - Non-Dependent or Dependent” can determine the order of benefits. This rule does not apply when the person is covered either: (a) as a non-dependent under both Plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as an employee or as a retired employee and is covered under his or her own Plan as an employee, Covered Person, subscriber or retiree); or (b) as a Dependent under both plans (i.e. the person is covered under a right of continuation as a qualified beneficiary who, on the day before a qualifying event, was covered under the group health plan as a dependent of an employee, Covered Person or subscriber or retired employee and is covered under the other plan as a dependent of an employee, Covered Person, subscriber or retiree).

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

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

EFFECT ON THE BENEFITS OF THIS PLAN
When a Covered Person is covered under two or more Plans which together pay more than this Plan’s benefits, the Plan will pay this Plan’s benefits according to the Order of Benefit Determination Rules. This Plan’s benefit payments will not be affected when it is Primary. However, when this Plan is Secondary under the Order of Benefit Determination Rules, benefits payable by this Plan will be reduced by the combined benefits of all other Plans covering You or Your Dependent.

When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan. If this Plan is secondary, the combined benefits of this Plan and the other Plan will never exceed what would have been provided by this Plan if primary. No benefits will be provided by this Plan when the amount paid by the other Plan is equal to or greater than the amount this Plan would have paid if Primary.

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

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

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

**RIGHT OF RECOVERY**
If the amount of the payments made by This Plan is more than should have paid under this COB provision, the Plan may recover the excess from one or more of the persons:
1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

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

**When a Covered Person Qualifies for Medicare**

**Determining Which Plan is Primary**
To the extent permitted by law, this Plan will pay benefits second to Medicare when You become eligible for Medicare, even if You don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- Covered Persons with active current employment status age 65 or older and their Spouses age 65 or older; and
- individuals with end-stage renal disease, for a limited period of time.

**Determining the Allowable Expense When This Plan is Secondary to Medicare**
If this Plan is secondary to Medicare, the Medicare approved amount is the Allowable Expense, as long as the Provider accepts Medicare. If the Provider does not accept Medicare, the Medicare limiting charge (the most a Provider can charge You if they don’t accept Medicare) will be the Allowable Expense. Medicare payments, combined with Plan benefits, will not exceed 100% of the total Allowable Expense.

If You are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if You had been enrolled in Medicare.
SUBROGATION AND REIMBURSEMENT

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

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

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

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether You are fully compensated, and regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- You and Your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.
- In the event that You or Your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by You, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to Your claim, Your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs You incur without the Plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

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

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on Your behalf regardless of whether the payments You receive make You whole for Your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of Your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan’s rights will not be reduced due to Your negligence.
- You and Your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of Your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon Your receipt of the Recovery. You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney You hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If You fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of Your Recovery whichever is less, from any future benefit under the Plan.
1. the amount the Plan paid on Your behalf is not repaid or otherwise recovered by the Plan; or
2. You fail to cooperate.

- In the event that You fail to disclose the amount of Your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of Your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on Your behalf. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse You.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate You or make You whole.

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

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

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

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

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

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

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

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

Protected Health Information Under HIPAA
This Section is intended as good faith compliance with the requirements of HIPAA and is to be construed in accordance with HIPAA and guidance issued thereunder. This Section is limited to benefits under the Plan that are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR 160 and 164, as amended) ("Privacy Regulations") and that are uninsured and provide Protected Health Information to The University.

The Plan will use Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by HIPAA, as set forth in the Privacy Regulations. Specifically, the Plan will use and disclose Protected Health Information for purposes related to health care "Treatment," "Payment" for health care, and "Health Care Operations," as those terms are defined in the Privacy Regulations.

In order for the Plan to disclose Protected Health Information to the University or to provide for or permit the disclosure of Protected Health Information to the University by a health insurance issuer or HMO with respect to the Plan, the Plan must ensure that the Plan documents restrict uses and disclosures of such information by the University consistent with the requirements of HIPAA.

The Plan may:

- Disclose Summary Health Information to the University, if the University requests the Summary Health Information for the purpose of:
  - Obtaining premium bids from health plans for providing health insurance coverage under the Plan or
  - Modifying, amending, or terminating the Plan.
"Summary Health Information" is as defined by 45 CFR § 164.504(a), as amended, which generally is information that may be individually identifiable health information, and:

- That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the University has provided health benefits under a group health plan; and
- From which the information described at § 164.514(b)(2)(i) of the Privacy Regulations has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) of the Privacy Regulations need only be aggregated to the level of a five digit zip code.

- Disclose to the University information on whether an Individual is participating in the Plan, or is enrolled in, or has disenrolled from a health insurance issuer or HMO offered by the Plan.
- Disclose Protected Health Information to the University to carry out Plan administration functions that the University performs, consistent with these provisions.
- With an authorization from the Covered Employee, disclose Protected Health Information to The University for purposes related to the administration of other employee plans and fringe benefits sponsored by the University.
- Not permit a health insurance issuer or HMO with respect to the Plan to disclose Protected Health Information to the University except as permitted here.
- Not disclose (and may not permit a health insurance issuer or HMO to disclose) Protected Health Information to the University as otherwise permitted unless a statement is included in the Plan's notice of privacy practices that the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Protected Health Information to the University.
- Not disclose Protected Health Information to the University for the purpose of employment-related actions or decisions or in connection with any other benefit or employee plan of The University.

The University may only use and disclose Protected Health Information as permitted and required by the Plan, as set forth here. Such permitted and required uses and disclosures may not be inconsistent with the provisions of HIPAA. The University may use and disclose Protected Health Information without an authorization from a Covered Employee for Plan administrative functions including Payment activities and Health Care Operations, as defined in the regulations. In addition, the University may also use and disclose Protected Health Information to accomplish the purpose for which any disclosure is properly made.

The Plan may disclose Protected Health Information to the University only upon receipt of a certification from the University that the Plan documents have been amended to incorporate the provisions provided for here and that the University so agrees to the provisions set forth therein.

The University agrees to:

- Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the University provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the University with respect to such Protected Health Information, and that any such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any Electronic Protected Health Information belonging to the Plan that is provided by the University;
- Not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose Protected Health Information in connection with any other benefit or employee plan of the University unless authorized by an individual;
- Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for here, or any Security Incident, of which it becomes aware;
- Make Protected Health Information available to an individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524;
- Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;
• Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
• Make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
• If feasible, return or destroy all Protected Health Information received from the Plan that the University still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);
• Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates receives, maintains, or transmits on behalf of the Plan; and
• Ensure that these separations and requirements are supported by reasonable and appropriate security measures.

In accordance with HIPAA, only the employees or classes of employees identified in the University's HIPAA Policies and Procedures may be given access to Protected Health Information. These persons may only have access to and use and disclose Protected Health Information for Plan administration functions related to the Health Care Operations that the University performs for the Plan.

If the persons or classes of persons described above do not comply with this Plan document, the Plan and the University will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Legal Compliance

Eligibility for Medicaid
Benefits will be paid in accordance with any assignment of rights made by or on behalf of any Covered Person as required by a State plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act. For purposes of enrollment and entitlement to benefits, a Covered Person's eligibility for or receipt of medical benefits under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. The State will have a right to any Payment made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make such Payment.

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

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

Medicare Program
When You are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payer, the benefits described in this Benefit Description will be reduced by the amount of benefits allowed
under Medicare for the same covered services. This reduction will be made whether or not You actually receive the benefits from Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

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

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

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

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

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

**Disputed Claims**
If You disagree with the determination of Your claim on appeal and you have exhausted Your remedies under the Plan as set forth in the Your Right To Appeal section, you may file a cause of action against the Plan. Any such cause of action must be filed within two years of the date that Your claim was initially denied by the Plan.

**Relationship of Parties (University-Covered Person-Claims Administrator)**
Neither the University nor any Covered Person is the agent or representative of the Claims Administrator.

The University is an agent of the Covered Person. The Claims Administrator’s notice to the University will constitute effective notice to the Covered Person. It is the University’s duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Covered Persons if the University fails to provide the Claims Administrator with timely notification of Covered Person enrollments or terminations.
Anthem Insurance Companies Inc. Note
The University, on behalf of itself and its Covered Persons, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the University and Anthem Insurance Companies Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

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

Modifications or Changes in Coverage
The Plan Sponsor may change the benefits described in this Benefit Booklet and the Covered Person will be informed of such changes as required by law. This Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions by the University, or by mutual agreement between the Claims Administrator and the University without the consent or concurrence of any Covered Person. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Covered Persons legally capable of contracting, and the legal representatives of all Covered Persons incapable of contracting, agree to all terms, conditions, and provisions hereof.

Fraud
Fraudulent statements on Plan enrollment forms or on electronic submissions will invalidate any payment or claims for services and be grounds for voiding the Covered Person’s coverage.

Acts Beyond Reasonable Control (Force Majeure)
Should the performance of any act required by this coverage be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive government laws or regulations, or any other cause beyond a party’s control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations.

The Claims Administrator will adhere to the Plan Sponsor’s instructions and allow the Plan Sponsor to meet all of the Plan Sponsor’s responsibilities under applicable state and federal law. It is the Plan Sponsor’s responsibility to adhere to all applicable state and federal laws and the Claims Administrator does not assume any responsibility for compliance.

Conformity with Law
Any provision of the Plan which is in conflict with the applicable federal laws and regulations is hereby amended to conform with the minimum requirements of such laws.
Clerical Error
Clerical error, whether of the Claims Administrator or the University, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

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

Under the terms of the Administrative Service Agreement with the University, the Claims Administrator has the authority, in its discretion, to institute from time to time, utilization management, care management, disease management or wellness pilot initiatives in certain designated geographic areas. These pilot initiatives are part of the Claims Administrator's ongoing effort to find innovative ways to make available high quality and more affordable healthcare. A pilot initiative may affect some, but not all Covered Persons under the Plan. These programs will not result in the payment of benefits which are not provided in the Plan, unless otherwise agreed to by the University. The Claim's Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to the University.

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

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

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

Payment Innovation Programs
The Claims Administrator pays Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.
These Programs may vary in methodology and subject area of focus and may be modified by the Claims Administrator from time to time, but they will be generally designed to tie a certain portion of a Network Provider’s total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Network Providers may be required to make payment to the Claims Administrator under the Program as a consequence of failing to meet these pre-defined standards.

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

Termination of Coverage (Individual)
Coverage under the Plan for You and Your enrolled family members may be continued as long as You are employed by the University and meet eligibility requirements. Coverage will terminate in the following situations:

- The date of the Covered Person's death
- The end of the month that You no longer meet eligibility requirements
- The date that the Plan is terminated
- The date You fail to timely make any required contribution toward the cost of Your coverage
- The date Dependent coverage or Eligible Retiree coverage is discontinued.

Should You or any family members be receiving covered care in the Hospital at the time Your coverage terminates for reasons other than the University’s termination of the Plan or Your failure to pay the required contribution toward the cost of coverage, benefits for Hospital Inpatient care will be provided until the date You are discharged from the Hospital.

Furnishing fraudulent or misleading material information relating to claims or application for coverage, or failure to timely notify the University that you are no longer eligible under the Plan will be deemed to be an act that constitutes fraud an intentional misrepresentation of material fact prohibited by the Plan that may result in a retroactive termination of coverage. You will be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.

Continuation of Coverage (COBRA)

If a Spouse’s or Dependent’s coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with federal law. You should contact the University if You have any questions about Your COBRA rights.

Qualifying Events for Continuation Coverage under Federal Law (COBRA)
COBRA continuation coverage is available when Your coverage would otherwise end because of certain “qualifying events.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A Spouse and Dependent Children could become qualified beneficiaries if covered on the day before the qualifying event and coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

Each member of Your family who is enrolled in the Plan can elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Parents or legal guardians may elect COBRA continuation coverage on behalf of their Dependent Children.

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Length of Availability of Coverage</th>
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<tbody>
<tr>
<td><strong>For Spouses/ Dependent Children:</strong></td>
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<tr>
<td>Divorce or Legal Separation from Eligible Retiree</td>
<td>36 months</td>
</tr>
<tr>
<td>Death of Eligible Retiree</td>
<td>36 months</td>
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If You are an Eligible Retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the University, and that bankruptcy results in the loss of coverage, You will become a qualified beneficiary with respect to the bankruptcy. Your Spouse and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to an Eligible Retiree and his or her covered family members as a result of a bankruptcy filing, the Eligible Retiree may continue coverage for life. Upon the death of an Eligible Retiree, his or her Spouse and Dependent Children may continue coverage for a maximum period of up to 36 months following the date of death.

Notification Requirements
In the event of Your Medicare entitlement, the University must notify the Plan Administrator within 30 days. You must notify the Plan Administrator within 60 days of the date of (or, if later, within 60 days of the date you would lose coverage under the Plan due to) Your divorce, legal separation, the failure of Your enrolled Dependents to meet the Plan’s definition of Dependent, or receiving notice of disability entitlement or cessation of disability. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights to elect continuation coverage within 14 days.

To continue enrollment, You or an eligible family member must make an election within 60 days of the date Your coverage would otherwise end, or the date the Plan Administrator notifies You or Your family member of this right, whichever is later. You must pay the total premium appropriate for the type of benefit coverage You choose to continue. If the premium rate changes for Eligible Employees, Your monthly premium will also change. The premium You must pay cannot be more than 102% of the premium charged for Eligible Employees with similar coverage, and it must be paid to the Plan Administrator within 30 days of the date due, except that the initial premium payment must be made before 45 days after the initial election for continuation coverage, or Your continuation rights will be forfeited.

When COBRA Coverage Ends
These benefits are available without proof of insurability and coverage will end on the earliest of the following:

- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA;
- a covered individual becomes entitled to Medicare after electing COBRA; or
- the University terminates all of its group welfare benefit plans.

Your coverage will end for cause on the same basis that the Plan can terminate coverage of a similarly situated non-COBRA beneficiary for cause.
DEFINITIONS

Accidental Injury
Bodily Injury sustained by a Covered Person 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 Covered Person
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.

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

Ambulance Services
A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which
offer non-emergency, convalescent or invalid care do not meet this definition.

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

Behavioral Health Care
Includes services for Mental Health Disorders, and Substance Abuse/Chemical Dependency.

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, and psychiatric conditions. This includes, but is
not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective 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.

Substance Abuse or Chemical Dependency
Any use of alcohol and/or drugs which produces a pattern of pathological use causing impairment
in social or occupational functioning or which produces physiological dependency evidenced by
physical tolerance or withdrawal. Substance abuse services include:

- Substance Abuse Rehabilitation Services, procedures and interventions to eliminate
dependence on or abuse of legal and/or illegal chemical substances, according to individual
treatment plans;
• Substance Abuse Services within a General Hospital Facility (a general hospital facility that provides services, on an inpatient, 24-hour basis, for medical detoxification and treatment of conditions associated with the addiction to or misuse of alcohol or other drugs.

Benefit Period
The 12 month period from January 1 to December 31 during which the Plan will pay benefits for covered services. It does not begin before a covered person's effective date and it ends when the covered person's coverage ends.

Centers of Excellence (COE) Network
A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein covered persons access select types of benefits through a specific network of medical centers.

A network of health care professionals contracted with the claims administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

Child or Children
A child means the eligible retiree's natural child, stepchild, legally adopted child, child who has been placed with the eligible retiree for adoption, or child placed with the eligible retiree by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction.

Claims Administrator
The company the University chose to administer its health benefits. Anthem Insurance Companies, Inc. was chosen to administer this Plan. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance
A specified percentage of the maximum allowable amount for covered services which you must pay. Coinsurance normally applies after the deductible (and does not include copayments) that you are required to pay. The coinsurance may be capped by the out-of-pocket maximum.

Combined Limit
The maximum total of network and out-of-network benefits available for designated health services in the schedule of benefits.

Complications of Pregnancy
Complications of pregnancy result from conditions requiring hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a complication of pregnancy.

Complications of pregnancy shall not include false labor, caesarean section, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as complications of pregnancy.

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

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Coordination of Benefits
A provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

Copayment
A specific dollar amount of Maximum Allowable Amounts for Covered Services. Your flat dollar Copayment will be the lesser of the amount shown on the Schedule of Benefits or the amount charged by the Provider. The Copayment does not apply toward any Deductible but applies to the Out-of-Pocket Maximum.

Cosmetic Surgery
Any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

Covered Person
An Eligible Retiree, Surviving Spouse or Dependent who has satisfied the Plan's eligibility conditions, applied for coverage, and enrolled in the Plan.

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

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

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

Covered Transplant Procedure
Any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

Custodial Care
Any type of 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 Covered Person 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 Covered Person’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 Covered Person, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, 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 dollar amount of Covered Services which you must pay before the Plan will pay for those Covered Services each Benefit Period.

**Denial**
A denial, reduction, termination or failure to provide or make Payment (in whole or in part) for a benefit, including determinations based on eligibility and utilization review, or a failure to cover a benefit because it is determined to be Experimental/Investigative or not Medically Necessary. It 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.

**Dependent**
- a Spouse.
- a Child until the end of the month in which the Child attains age 26.
- a grandchild of the Eligible Employee or Eligible Retiree if the grandchild is the tax dependent of the Eligible Employee or Eligible Retiree.
- a Child after the end of the month in which the Child attains age 26, if the child is a Dependent under the Plan prior to attaining age 26, a tax dependent of the Eligible Employee or Eligible Retiree, and permanently and totally disabled. A Child is permanently and totally disabled if the child is unable to engage in any substantial gainful activity due to a medically-determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of 12 or more months. Proof of permanent and total disability must be provided to the Claims Administrator within 31 days of attainment of age 26 and proof of continued permanent and total disability may be required by the Claims Administrator on an annual basis thereafter.

**Detoxification**
The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

**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.

**Diagnostic**
A test or procedure performed on a Covered Person who is displaying specific symptoms to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for a Covered Person who is not displaying any symptoms.
Durable Medical Equipment
Equipment 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 of use to persons who do not have a disease or Injury; (e) not for exercise or training.

Effective Date
The date for which the Plan approves an individual application for coverage. For individuals who join this Plan after the first enrollment period, the Effective Date is the date the Claims Administrator approves each future Covered Person according to its normal procedures.

Elective Surgical Procedure
A surgical procedure that is not considered to be an emergency, and may be delayed by the Covered Person to a later point in time.

Electronic Protected Health Information or EPHI
"Electronic Protected Health Information" as defined at 45 CFR § 160.103, which, generally, means Protected Health Information that is transmitted by, or maintained in, electronic media. For these purposes, "electronic media" means: (i) electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or (ii) transmission media used to exchange information already in electronic storage media (e.g., the internet, extranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media).

 Eligible Employee
An Eligible Employee includes:

- Tenure, tenure track and contract faculty members assigned to teach six or more credit hours each semester;
- Contract and continuing contract professional personnel assigned to work 20 or more hours a week;
- Staff personnel and service personnel assigned to work 30 hours or more a week; and
- Any other common law employee of the University who is determined to be a Full-Time Employee, defined and determined in accordance with Appendix A.

An Eligible Employee shall continue to be an Eligible Employee if he or she (i) is eligible for and receives long-term disability benefits under the University's long term disability program or (ii) is on an approved sick, pregnancy or child care leave with the University pursuant to its leave policy, but for no longer than the following periods: (1) two years, if he or she has at least one but less than five years of service with the University; (2) three years, if he or she has at least five but less than ten years of service with the University or (3) through the end of the fiscal year in which he or she attains age 66, if he or she has ten or more years of service with the University.

An Eligible Employee does not include:

- Any individual who is a nonresident alien who receives no earned income (within the meaning of Code Section 911(d)(2)) from the University which constitutes income from sources within the U.S. under Code Section 861(a)(3);
- Volunteers with the University;
- Any leased or contract employees, as defined under Code Section 414(n); or
- Any person designated in good faith by the University as an independent contract, regardless of whether such person is later determined to be a common law employee for tax purposes.

Eligible Retiree
An Eligible Employee who retires from the University, who is a faculty, professional, staff or service Covered Person, and whose last date of hire:
• precedes July 1, 2009 must be at least age 50 and have at least 15 years of continuous years of service
• is on or after July 1, 2009, must be at least 62 years of age and have at least 15 years of continuous years of service.

An Eligible Employee who retires from the University, who is an eligible contract faculty Covered Person, and whose last date of hire:
• precedes July 1, 2009 must be at least age 50 and have at least 15 years of cumulative full-time years of service
• is on or after July 1, 2009, must be at least 62 years of age and have at least 15 years of cumulative full-time years of service.

Emergency Medical Condition
(“Emergency Services,” “Emergency Care Services,” or “Medical Emergency”) Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:
• Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
• Serious impairment to bodily functions; or
• Serious dysfunction of any bodily organ or part.

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

The Claims Administrator will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:
• Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
• Has been determined by the FDA to be contraindicated for the specific use; or
• Is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
• Is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a Service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:
• The scientific evidence is conclusory concerning the effect of the service on health outcomes;
• The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

• The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and

• The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

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

• Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or

• Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or

• Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

• Documents of an IRB or other similar body performing substantially the same function; or

• Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or

• Medical records; or

• The opinions of consulting Providers and other experts in the field.

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

External Review
A review of a Denial (including a Final Denial) of benefits conducted pursuant to the External Review process.

Final Denial
A Denial of benefits that has been upheld by the Claims Administrator at the completion of the internal appeals process, or a Denial of benefits with respect to which the internal appeals process has been deemed exhausted.

Final External Review Decision
A determination by an Independent Review Organization at the conclusion of External Review.
Freestanding Ambulatory Facility
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 and accredited by the appropriate agency. A Physician’s office does not qualify as a Freestanding Ambulatory Facility.

Health Care Operations
Health Care Operations include, but are not limited to, the following activities taken by or on behalf of the Plan:

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care Providers and patients with information about treatment alternatives and related functions;
- Rating Provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including Formulary development and administration, development or improvement of Payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to:
  - Management activities relating to the implementation of and compliance with HIPAA’s administrative simplification requirements;
  - Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
  - Resolution of internal Complaints;
  - Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a “covered entity” under HIPAA or, following completion of the sale or transfer, will become a covered entity; and
- Any other activity considered to be a “health care operation” activity pursuant to 45 CFR § 164.501.

Health Care Professional
A Physician or other health care professional licensed, accredited, or certified to perform health services consistent with State law.

HIPAA
The Health Insurance Portability and Accountability Act of 1996, as amended

Home Health Care
Care, by a 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 and accredited by the appropriate agency.

**Hospice**
A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient’s Physician. It must be licensed and accredited by the appropriate agency.

**Hospice Care Program**
A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member 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 and accredited by the appropriate 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.

**Hospital**
An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. “Hospital” does not mean other than incidentally:
- an extended care facility; nursing home; place for rest; facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

**Identification Card**
The latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

**Independent Review Organization (IRO)**
An entity that conducts independent External Reviews of Denials and Final Denials.

**Ineligible Charges**
Charges for health care services that are not Covered Services because the services are not Medically Necessary or Precertification was not obtained. Such charges are not eligible for payment.

**Ineligible Provider**
A provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Covered Person by such a provider are not eligible for payment.

**Infertile or Infertility**
The condition of a presumably healthy Covered Person 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.

**Injury**
Bodily harm from a non-occupational accident.
Inpatient
A Covered Person 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 Dependent under the Plan.

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

Medical Facility
A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Benefit booklet. The facility must be licensed, accredited, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific requirements established by the Claims Administrator.

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

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

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

Network Provider
A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Covered Persons through negotiated reimbursement arrangements.

**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**

A Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to its Covered Persons at the time services are rendered. Benefit payments and other provisions of this Plan are limited when a Covered Person uses the services of Out-of-Network Providers.

**Out-of-Pocket Maximum**

The maximum amount of a Covered Person's Deductible, Coinsurance and Copayments during a Benefit Period. When the Out-of-Pocket Maximum is reached for a Covered Person, then the Plan pays 100% of the Maximum Allowed Amount for Covered Services.

**Payment**

Activities which include, but are not limited to, activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to a Covered Person to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and Copayments as determined for a Covered Person's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other Payment disputes);
- Subrogation of health benefit claims;
- Establishing contributions;
- Risk adjusting amounts due based on a Covered Person's health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing Payments, investigating and resolving Payment disputes and responding to a Covered Person's inquiries about Payments;
- Obtaining Payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for Payment purposes: name and address, date of birth, Social Security number, Payment history, account number and name and address of the Provider and/or health plan);
- Reimbursement to the Plan; and
- Any other activity considered to be a "Payment" activity pursuant to 45 CFR § 164.501.

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

**Physical Therapy**
The care of disease or injury by such methods as massage, hydrotherapy, heat, or similar care.

**Physician**
Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., 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 (Ph.D) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

**Plan**
The Ball State University Retiree Health Plan, a self-funded group health plan sponsored by the University for its Eligible Retirees comprised of the following options: High Deductible Wellness PPO Plan, the HSA Qualified Health Plan, the Low Deductible PPO Plan, and the Over 65 Retiree Health Plan.

**Plan Administrator**
The person or entity named by Ball State University to manage the Plan and answer questions about Plan details. *The Plan Administrator is not the Claims Administrator.*

**Plan Sponsor**
Ball State University.

**Post-Service Claim**
Any claim that is not a Pre-Service Claim or an Urgent Care Claim.

**PPACA**
The Patient Protection and Affordable Care Act of 2010 as amended.

**Pre-Service Claim**
Any claim whereby the Plan conditions receipt of such benefit, in whole or in part, on approval of the benefit prior to obtaining medical care.

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

**Protected Health Information**
"Protected health information" as defined at 45 CFR § 164.501 which, generally, means information (including demographic information) that (i) identifies an individual (or with respect to which there is a reasonable basis to believe the information can be used to identify an individual), (ii) is created or received by a health care provider, a health plan, or a health care clearinghouse, and (iii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future Payment for the provision of health care to an individual.
**Provider**
A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider.

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

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

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

**Rescission or Rescind**
A cancellation or discontinuance of Your coverage that has retroactive effect. A rescission does not include the cancellation or discontinuance of Your coverage if it (i) only has a prospective effect, or (ii) is effective retroactively, to the extent it is attributable to Your failure to timely pay Your cost of coverage.

**Retail Health Clinic**
A facility that provides limited basic medical care services to Covered Persons on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.

**Security Incident**
"Security incident" as defined at 45 CFR § 164.304, which, generally, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

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

**Skilled Convalescent Care**
Care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient’s home or in a nursing home not certified as a Skilled Nursing Facility.

**Skilled Nursing Facility**
An institution operated alone or with a Hospital which gives care after a Covered Person leaves the Hospital for a condition requiring more care than can be rendered 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 determined by the Claims Administrator to meet the reasonable standards applied by any of the aforesaid authorities.
Specialist (Specialty Care Physician|Provider or SCP)
A Specialist is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Spouse
Spouse means a person to whom the Eligible Employee or Eligible Retiree is legally married under federal tax law.

Surviving Spouse
The surviving Spouse of a deceased Eligible Retiree who was a Covered Person under the Plan at the time of death.

Therapeutic Equivalent
Therapeutic/Clinically Equivalent drugs are drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

Transplant Providers
Network Transplant Provider - A Provider that has been designated as a “Center of Excellence” for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:
- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

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

University
Ball State University.

Urgent Care
Services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

Urgent Care Claim
Any claim for medical care or treatment where the failure to make a non-urgent care determination quickly: (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or (ii) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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 and Your
Refer to a Covered Person.
HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Statement of Rights Under the Newborns’ and Mother’s Health Protection Act
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than

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

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

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

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

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

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

Coverage for a Child Due to a Qualified Medical Support Order (“QMCSO”)
If You or Your spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You may ask the University or Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

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

- **Plan Name:** Ball State University Retiree Health Plan
- **Plan Sponsor:** Ball State University
  
  2000 University Avenue
  Muncie, IN 47306

- **University I.D. Number:** 35-6000221
- **Type of Plan:** The Plan is an employee welfare benefit plan providing group medical benefits.
- **Plan Year Ends:** December 31
- **Type of Administration/Funding:** Medical benefits are self-funded by the University and claims are administered by Anthem Blue Cross Blue Shield (IN) on behalf of the University
- **Plan Administrator:** Ball State University
- **Agent for Service of Legal Process:** Ball State University

The Anthem National Accounts business unit serves members of: Anthem Blue Cross Life and Health Insurance Company and Blue Cross of California using the trade name Anthem Blue Cross in California; using the trade name of Anthem Blue Cross and Blue Shield for the following companies in: Colorado Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Connecticut: Anthem Health Plans, Inc.; Georgia: Blue Cross and Blue Shield of Georgia, Inc. and Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.; Indiana: Anthem Insurance Companies, Inc.; Kentucky: Anthem Health Plans of Kentucky, Inc.; Maine: Anthem Health Plans of Maine, Inc.; Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits; Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada.; New Hampshire: Anthem Health Plans of New Hampshire, Inc.; Ohio: Community Insurance Company; Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123.; Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. In 28 eastern and southeastern counties in New York, Empire Blue Cross Blue Shield, the trade name of Empire HealthChoice Assurance, Inc., underwrites and/or administers the PPO, EPO, POS and indemnity policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.