Anthem BlueCross BlueShield

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Muskego Norway School District

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Medical benefits administered by Wisconsin Collaborative Insurance Company

Your Health Benefit Booklet

Health Benefit Booklet

Well Priority POS

Important Notice Regarding Payment of Covered Services

Your Plan limits benefits for Covered Services to the Maximum Allowable Amount, as defined in the "Definitions" section at the back of this Benefit Booklet. The Maximum Allowable Amount may be less than the amount billed by your Provider. Please see page M-108 in the "General Provisions" section for information on how to determine what the Plan will cover as the Maximum Allowable Amount.

Administered by
Wisconsin Collaborative Insurance Company
("WCIC")
Blue Cross Blue Shield of Wisconsin
dba Anthem Blue Cross and Blue Shield

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

ASO - BCBSWI/CCB-06 (1/17)

1 INTRODUCTION

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

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

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

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

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

If you have any questions about this Benefit Booklet, please call the member service number located on the back of your Identification (ID) Card or visit www.anthem.com.

How to Obtain Language Assistance

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

Identity Protection Services

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

2 FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

3 Member Rights and Responsibilities

As a Member you have rights and responsibilities when receiving health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That means giving you access to our 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 us to keep your personal health information private by following our 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:
    - Our company and services.
    - Our 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 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 us, 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 Plan. This may include information about other health insurance benefits you have in addition to your Plan with us.
- 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 us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

We want to provide high quality benefits and customer service to our Members. Benefits and coverage for services given under the plan are governed by the Benefit Booklet and not by this Member Rights and Responsibilities statement.

Contents

4 SCHEDULE OF BENEFITS

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

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

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

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

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

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

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

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

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

BENEFIT PERIOD	Calendar Year

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

Please see the "Eligibility and Enrollment" section for further details.

DEDUCTIBLE

	Network	Non-Network
Per Member	$500	$1,000
Per Family	$1,000	$2,000

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

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

- Emergency Room services when subject to a Copayment plus Coinsurance

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

OUT-OF-POCKET LIMIT

	Network	Non-Network
Per Member	$2,000	$4,000
Per Family	$4,000	$8,000

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

- Non-Network Human Organ and Tissue Transplant services

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

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

COVERED SERVICES	COPAYMENTS/COINSURANCE/MAXIMUMS	
	Network	**Non-Network**
Ambulance Services (Air and Water)	10% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.

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

Ambulance Services (Ground)	10% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.

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

Autism Services	Copayments / Coinsurance based on setting where Covered Services are received.	Copayments / Coinsurance based on setting where Covered Services are received.
Behavioral Health & Substance Abuse Services		
• Inpatient Facility Services	10% Coinsurance	30% Coinsurance
• Inpatient Professional Services	10% Coinsurance	30% Coinsurance
• Outpatient Facility Services (Includes Outpatient Hospital / Alternative Care Facility and Transitional Care)	10% Coinsurance	30% Coinsurance
• Outpatient Professional Services (Includes Transitional Care)	10% Coinsurance	30% Coinsurance
• Office Visits (Including Online Visits)	$20 Copayment per visit	30% Coinsurance
• Other Outpatient Services	10% Coinsurance	30% Coinsurance

Benefits are also available for Dependent students outside the Service Area. Please see the "Covered Services" section for further details.

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

Childhood Immunizations	Please refer to the "Preventive Care Services" provision in this Schedule.

Chiropractor Services	Chiropractor Services are paid as any other Physician service. The PCP Copayment will apply. Please refer to "Physician Home Visits and Office Services" for details.	Chiropractor Services are paid as any other Physician service. Please refer to "Physician Home Visits and Office Services" for details.

Note: If therapy services are provided, those services will be subject to the limits listed under "Therapy Services."

Dental Services (Does not include routine dental care.)	Copayments / Coinsurance based on setting where Covered Services are received.	Copayments / Coinsurance based on setting where Covered Services are received.

Diabetic Equipment, Education, and Supplies	Copayment / Coinsurance is based on the setting where Covered Services are received For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. Screenings for gestational diabetes are covered under "Preventive Care." For information on Prescription Drug coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	When rendered as Physician Home Visits and Office Services or Outpatient Services, the Copayment / Coinsurance is based on the setting where Covered Services are received except as listed below. Other Diagnostic Services and or tests, including services received at an independent Network lab, may not require a Copayment / Coinsurance. Laboratory services provided by a facility participating in Our Laboratory Network (as shown in the Provider directory) may not require a Coinsurance / Copayment. If laboratory services are provided by an Outpatient Hospital laboratory that is not part of Our Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit.

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

Emergency Room Services Copayment / Coinsurance is waived if you are admitted	$150 Copayment per visit plus an additional 10% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.
Home Care Services	10% Coinsurance	30% Coinsurance
Maximum Visits per Benefit Period	Unlimited	

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

Private Duty Nursing	
Maximum per Member per Benefit Period	Unlimited
Lifetime Maximum	Unlimited

Hospice Services	10% Coinsurance	30% Coinsurance
Inpatient and Outpatient Professional Services	10% Coinsurance	30% Coinsurance
Inpatient Facility Services	10% Coinsurance	30% Coinsurance
Maximum days per Benefit Period for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	Unlimited	
Maximum days per admission for Skilled Nursing Facility	100 days, combined Network and Non-Network The Plan will not pay less than the daily rate set for Skilled Nursing Facilities by the Wisconsin Department of Health and Family Services.	

Kidney Disease Treatment	Kidney disease benefits include dialysis, transplantation, donor-related costs, and transplant-related services. Covered Services are subject to Copayments / Coinsurance based on the setting where Covered Services are received.	
Lead Poisoning Screening	Please see the "Preventive Care Services" provision in this Schedule.	
Mammograms (Outpatient)		
• **Diagnostic mammograms**	No Copayment / Coinsurance up to the Maximum Allowable Amount.	30% Coinsurance
• **Routine mammograms**	Please see the "Preventive Care Services" provision in this Schedule.	
Maternity Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Network Pharmacy.)	10% Coinsurance	30% Coinsurance
Benefit Period Maximum for Hearing Aids Prescribed to Children Under Age 18	One hearing aid per ear, per child, once every three years combined Network and Non-Network	

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

Nurse Practitioner Services	Please refer to the "Physician Home Visits and Office Services" provision in this Schedule.	
Outpatient Services		
Outpatient Surgery Hospital/ Alternative Care Facility	10% Coinsurance	30% Coinsurance

Other Outpatient Services	10% Coinsurance	30% Coinsurance

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

Physician Home Visits and Office Services		
Primary Care Physician (PCP)	$20 Copayment per visit	30% Coinsurance
Specialty Care Physician (SCP)	$40 Copayment per visit	30% Coinsurance
Online Visits (Other than Behavioral Health & Substance; see Behavioral Health & Substance section for further details)	$20 Copayment per visit	30% Coinsurance
Allergy Injections	10% Coinsurance	30% Coinsurance

Note: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs (except immunizations covered under "Preventive Care Services" in the Benefit Booklet) received in a Physician's office are subject to the Other Outpatient Services Copayment / Coinsurance.

The allergy injection Copayment/Coinsurance will be applied when the injection(s) is billed by itself. The office visit Copayment/Coinsurance will apply if an office visit is billed with an allergy injection.

Preventive Care Services	No Copayments / Coinsurance to the Maximum Allowable Amount.	30% Coinsurance
• **Childhood Immunizations**	Benefits are available for childhood immunizations for Dependents.	
• **Lead Poisoning Screening**	Benefits are available for lead poisoning screenings for Dependents.	
• **Mammograms**	Benefits are available for routine mammograms.	
• **Colorectal Screening**	Benefits are available for routine colorectal cancer examinations and related laboratory tests.	

Skilled Nursing Facility Services	Please refer to the "Inpatient Facility Services" provision in this Schedule.	
Surgery	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received
Temporomandibular and Craniomandibular Joint Disease Treatment	Copayments / Coinsurance based on setting where Covered Services are received.	
Therapy Services	Copayments / Coinsurance based on setting where Covered Services are received	Copayments / Coinsurance based on setting where Covered Services are received

Note: If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below.

Maximum Visits per Benefit Period for:	
Physical Therapy	Unlimited visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply instead of the limit listed here.
Occupational Therapy	Unlimited visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply instead of the limit listed here.This limit does not apply to Autism Services.
Speech Therapy	Unlimited visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply instead of the limit listed here. This limit does not apply to Autism Services.
Cardiac Rehabilitation	Unlimited visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply instead of the limit listed here.

Pulmonary Rehabilitation	Unlimited visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply instead of the limit listed here. When rendered as part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	
Urgent Care Center Services	$50 Copayment per visit plus an additional 10% Coinsurance	30% Coinsurance
Allergy injections	10% Coinsurance	30% Coinsurance

NOTES: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs received in an urgent care center are subject to the Other Outpatient Services Copayment / Coinsurance.

The allergy injection Copayment / Coinsurance will be applied when the injection(s) is billed by itself. The urgent care visit Copayment / Coinsurance will apply if an urgent care visit is billed with an allergy injection.

Human Organ and Tissue Transplant Services (Bone Marrow/Stem Cell)

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

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

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

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 Us to determine which Hospitals are Network Transplant Providers. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.)

Transplant Benefit Period	**Network Transplant Provider**	**Non-Network Transplant Provider**

	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Contact the Case Manager for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility.	Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non- Network Transplant Provider Facility.
Deductible	**Network Transplant Provider**	**Non-Network Transplant Provider**
	Not Applicable	Applicable. During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.
Covered Transplant Procedure during the Transplant Benefit Period	**Network Transplant Provider Facility**	**Non-Network Transplant Provider Facility**
• **Precertifiation required**	During the Transplant Benefit Period, No Copayment / Coinsurance up to the Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.	During the Transplant Benefit Period, You will pay 50% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also a Network Provider for the Plan (for services other than Covered Transplant Procedures), then you will **not** be responsible for Covered Transplant Procedures that exceed the Plan's Maximum Allowable Amount.

		If the Provider is a Non-Network Provider for the Plan, you **will** be responsible for Covered Transplant Procedures that exceed the Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	**Network Transplant Provider Professional and Ancillary (non-Hospital) Providers**	**Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers**
	No Copayment / Coinsurance up to the Maximum Allowable Amount	You are responsible for 50% of the Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	Covered, as allowed by the Plan, up to a $10,000 per transplant benefit limit.	For Transplants received at a Non-Network Transplant Provider Facility, covered as allowed by the Plan, up to a maximum of $10,000 in charges. You will pay 50% of the approved amount. These charges will NOT apply to your Out-of-Pocket Limit.
Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure	Covered, as allowed by the Plan, up to a $30,000 per transplant benefit limit.	Covered, as allowed by the Plan, up to a $30,000 per transplant benefit limit. You will be responsible for 50% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.

Live Donor Health Services	Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	You will pay 50% of the Maximum Allowable Amount for medically necessary live organ donor expenses. These charges will NOT apply to your Out-of-Pocket Limit. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement.

Prescription Drugs

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

Retail Pharmacy (Network and Non-Network)	30
Mail Service	90
Specialty Pharmacy	30* See additional information in Specialty Network Retail / Specialty Mail Service section below.

Network Retail Pharmacy Prescription Drug Copayment/Coinsurance:

Tier 1 Prescription Drugs	$5 Copayment per Prescription Order
Tier 2 Prescription Drugs	$10 Copayment per Prescription Order
Tier 3 Prescription Drugs	$25 Copayment per Prescription Order
Tier 4 Prescription Drugs	Not available at Retail Pharmacies. See Specialty Network Retail / Specialty Mail Service information below.

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

Tier 1 Prescription Drugs	$12.50 Copayment per Prescription Order
Tier 2 Prescription Drugs	$25 Copayment per Prescription Order
Tier 3 Prescription Drugs	$65.50 Copayment per Prescription Order
Tier 4 Prescription Drugs	See Specialty Network Retail / Specialty Mail Service information below.

Specialty Network Retail, Including Specialty Mail Service Program, Prescription Drug Copayment / Coinsurance:

*Note: Certain Specialty Drugs in Tiers 1–3 (including but not limited to oral HIV drugs and immunosuppressant drugs) may be dispensed in up to a 90-day supply, subject to the Mail Service Copayments listed above. When a 30-day supply is obtained, the Copayments listed below will apply. Specialty Drugs in Tier 4 are limited to a 30-day supply.

Tier 1 Specialty Prescription Drugs	$5 Copayment per Prescription Order
Tier 2 Specialty Prescription Drugs	$10 Copayment per Prescription Order
Tier 3 Specialty Prescription Drugs	$25 Copayment per Prescription Order
Tier 4 Specialty Prescription Drugs	$150 Copayment per Prescription Order

Note: Prescription Drugs will always be dispensed as ordered by your Physician. You may request, or your Physician may order, the Tier 2 or Tier 3 Drug. However, if a Tier 1 Drug is available, you will be responsible for the difference in the cost between the Tier 1 and Tier 2 or Tier 3 Drug, in addition to your Tier 1 Copayment / Coinsurance. If a Tier 1 Drug is not available, or if your Physician writes "Dispense as Written" or “Do not Substitute” on your Prescription, you will only be required to pay the applicable Tier 2 or Tier 3 Copayment / Coinsurance. You will not be charged the difference in cost between the Tier 1 and Tier 2 or Tier 3 Prescription Drug. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet provides the same quality. For certain higher cost generic drugs, we reserve the right, in our sole discretion, to make an exception and not require you to pay the difference in cost between the Generic and Brand Name Drug.

Non-Network Retail Pharmacy Prescription Drug Copayment:	50% Coinsurance (minimum $25) per Prescription Order

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

ASO - BCBSWI/CCB-06/PPO&POS-SB (1/17)

5 COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **To receive maximum benefits for Covered Services, care must be received from a Primary Care Physician (PCP), a Specialty Care Physician (SCP), or another Network Provider. Services that are not received from a PCP, SCP, or another Network**

Provider will be considered a Non-Network service, unless otherwise indicated in this Benefit Booklet. The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP, another Network Provider, or a Non-Network Provider.

Please refer to the "How to Obtain Covered Services" section of this Benefit Booklet for additional details about the Plan's requirements.

If you use a Non-Network Provider, you are responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. The Plan cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

All Covered Services and benefits are subject to the conditions, exclusions, limitations, terms, and provisions of this Benefit Booklet, including any attachments, riders, and endorsements. Covered Services must be Medically Necessary and not Experimental / Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Plan, including receipt of care from a PCP, SCP, or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization / Precertification has been obtained. Decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services, and new technology are based on Our clinical coverage guidelines and medical policy. Published peer-review medical literature, opinions of experts, and the recommendations of nationally recognized public and private organizations, which review the medical effectiveness of health care services and technology may also be considered.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Benefit Booklet. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. The Plan's payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, or Benefit Period Limit/Maximum in this Benefit Booklet.**

Acupuncture Services

- Acupuncture services are covered.

Ambulance Services

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

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

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

- Between Hospitals, including when We require you to move from a Non-Network Hospital to a Network Hospital
- Between a Hospital and a Skilled Nursing Facility or other approved Facility.

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

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

Non-Emergency ambulance services are subject to Medical Necessity reviews by Us. When using an air ambulance for non-Emergency transportation, We reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider We select, no benefits will be available.

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

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

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

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

a) A Doctor's office or clinic;

b) A morgue or funeral home.

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Autism Services

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

Benefits are available for the treatment of Autism Spectrum Disorders. The following definitions apply to this section only:

Autism Spectrum Disorder means any of the following: (1) Autism Disorder; (2) Asperger's Syndrome; or (3) Pervasive Developmental Disorder Not Otherwise Specified.

Behavioral means interactive therapies that target observable behaviors to build needed skills and to reduce problem behaviors using well-established principles of learning utilized to change socially important behaviors with the goal of building a range of communication, social and learning skills, as well as reducing challenging behaviors.

Department means the Wisconsin Department of Health Services.

Evidence-Based means therapy that is based upon medical and scientific evidence and is determined to be an efficacious treatment or strategy.

Efficacious Treatment or Efficacious Strategy means treatment or strategies designed to address cognitive, social or behavioral conditions associated with Autism Spectrum Disorders; to sustain and maximize gains made during Intensive-Level Services; or to improve the condition of a Member with Autism Spectrum Disorder.

Intensive-Level Services means Evidenced-Based behavioral therapies that are directly based on, and related to, a Member's therapeutic goals and skills as prescribed by a Physician familiar with the Member.

Nonintensive-Level Services means Evidence-Based therapy that occurs after the completion Intensive-Level Services that is designed to sustain and maximize gains made during treatment with Intensive-Level Services. It also includes Evidence-Based therapy for a Member who has not and will not receive Intensive-Level Services, but for whom Nonintensive-Level Services will improve the Member's condition.

Provider means a state-licensed Psychiatrist, Psychologist, or a Social Worker certified or licensed to practice psychotherapy. It also means a Behavior Analyst who has been licensed by the State of Wisconsin and has been certified by the Behavior Analyst Certification Board, Inc.

Qualified Paraprofessional means an individual working under the active supervision of, and received regularly scheduled oversight by, a Qualified Supervising Provider and who is at least 18 years of age and has completed certain training requirements, as specified in Ins 3.36, Wis. Admin. Code.

Qualified Professional means an individual working under the supervision of an outpatient mental health clinic who is a licensed treatment professional as defined in s. DHS 35.03 (9g), and, to the extent they provide Intensive-Level Services, has completed the training requirements specified in Ins 3.36, Wis. Admin. Code.

Qualified Provider means a Provider acting within the scope of a currently valid state-issued license to practice psychotherapy. If the Provider provides Intensive-Level Services, the Provider must also satisfy the training requirements specified in Ins 3.36, Wis. Admin. Code.

Qualified Supervising Provider means a Qualified Provider that has completed at least 4,160 hours of experience as a supervisor of less experienced Providers, Professionals and Paraprofessionals.

Therapy means services, treatments and strategies prescribed by a treating Physician and provided by a Qualified Provider to improve the Member's condition or to achieve social, cognitive, communicative, self-care or Behavioral goals that are clearly defined within the Member's treatment plan.

Therapist means a state-licensed speech-language pathologist or occupational therapist acting within the scope of their currently valid license and who provides Evidence-Based services.

Waiver Program means services provided by the Department through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare & Medicaid Services.

Benefits for the Treatment of Autism Spectrum Disorders

Benefits include the Covered Services described below for Members who have a verified diagnosis of Autism Spectrum Disorder. We will also pay benefits for services provided by a Therapist that are provided with Intensive-Level Services. We may require the Member to obtain a second opinion to verify the diagnosis.

1. **Intensive-Level Services.** We will pay benefits for Intensive-Level Services, the majority of which shall be provided to the Member when the parent or legal guardian is present and engaged. Intensive-Level Services must meet all of the following requirements:

    a. Be based upon a treatment plan developed by a Qualified Provider that includes at least 20 hours per week over a six-month period of time of Evidence-Based Behavioral Intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the Member be present and engaged in the intervention. We may request and review the Member's treatment plan and the summary of progress on a periodic basis;
    b. Implemented by Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Therapists or Qualified Paraprofessionals;
    c. Provided in an environment most conducive to achieving the goals of the Member's treatment plan;
    d. Include training and consultation, participation in team meetings and active involvement of the Member's family and treatment team for implementation of the therapeutic goals developed by the team;
    e. Begin after a Member is two years of age and before the Member is nine years of age; and
    f. The Member is directly observed by the Qualified Provider at least once every two months.

2. **Nonintensive-Level Services.** We will pay benefits for Nonintensive-Level Therapy Services that are Evidenced-Based provided to a Member by a Qualified Provider, Qualified Professional, Therapist or Qualified Paraprofessional in either of the following situations:

    a. After the completion of Intensive-Level Services, when services are designed to sustain and maximize gains made during Intensive-Level Services treatment; or
    b. To a Member who has not and will not receive Intensive-Level Services but for whom Nonintensive-Level Services will improve their condition.

    Nonintensive-Level Services must meet all of the following requirements:

    a. Be based upon a treatment plan developed by a Qualified Provider, Qualified Supervising Provider, Qualified Professional or Therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the Member be present and engaged in the intervention. We may request and review the Member's treatment plan and the summary of progress on a periodic basis;

b. Implemented by Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Therapists or Qualified Paraprofessionals;
c. Provided in an environment most conducive to achieving the goals of the Member's treatment plan;
d. Includes training and consultation, participation in team meetings and active involvement of the Member's family and treatment team for implementation of the therapeutic goals developed by the team;
e. Provides supervision of Qualified Providers, Qualified Professionals, Therapists and Qualified Paraprofessionals by Qualified Supervising Providers on the treatment team.

Transition from Intensive-Level Services to Nonintensive-Level Services – We shall provide a Member, or his/her authorized representative, notice of the change in a Member's level of treatment. The notice shall indicate the reason for the transition that may include any of the following:

1. The Member has received four cumulative years of Intensive-Level Services;
2. The Member no longer requires Intensive-Level Services as supported by documentation from a Qualified Provider or Qualified Supervising Provider; or
3. The Member no longer receives Evidence-Based therapy for at least 20 hours per week over a six month period of time.

The Member, or his/her representative, should notify us if he/she is unable to receive Intensive-Level Services for an extended period of time. The notification must indicate the specific reason(s) the Member or the Member's family or care giver is unable to comply with an Intensive-Level Service treatment plan. Reasons for requesting an interruption in Intensive-Level Services for an extended period of time may include a significant medical condition, surgical intervention and recovery, catastrophic event or any other reason acceptable to us. We will not deny Intensive-Level Services to a Member for failing to maintain at least 20 hours per week of Evidence-Based Behavioral therapy over a six-month period when:

1. The Member notifies us as stated above; or
2. The Member, or his/her authorized representative, can document that the Member failed to maintain at least 20 hours per week of Evidence-Based Behavioral therapy due to waiting for Waiver Program services.

Exclusions

The "Autism Services" section of this Benefit Booklet is not subject to the exclusions listed in the "Non-Covered Services" section. Instead, the "Autism Services" provision is subject to the exclusions listed below. The Plan provides no benefits for:

1. Services that are not Evidence-Based.
2. Acupuncture;
3. Animal-based therapy including hippotherapy;
4. Auditory integration training;
5. Chelation therapy;

6. Child care fees;
7. Cranial sacral therapy;
8. Custodial or respite care;
9. Hyperbaric oxygen therapy;
10. Special diets or supplements;
11. Travel time by Qualified Providers, Qualified Supervising Providers, Qualified Professionals, Therapists or Qualified Paraprofessionals;
12. Costs for the facility or location, or for the use of a facility or location, when treatment, therapy or services are provided outside of a Member's home;
13. Claims that have been determined by Us to be fraudulent; and
14. Treatment provided by parents or legal guardians who are otherwise Qualified Providers, Qualified Supervising Providers, Therapists, Qualified Professionals or Paraprofessionals for treatment provided to their own children.

Note: The benefits in this section do not include benefits for durable medical equipment and Prescription Legend Drugs. Please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" and "Prescription Drugs" provisions of this Benefit Booklet for details on coverage of those services.

Behavioral Health and Substance Abuse Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance / Copayment information. Coverage for the treatment of Behavioral Health and Substance Abuse conditions is provided in compliance with federal law.

Covered Services include the following:

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

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

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

  Transitional Care is covered in the following settings:

  1. A certified Adult Mental Health Day Treatment Program as defined in HFS 61.75 Wis. Adm. Code.
  2. A certified Child/Adolescent Mental Health Day Treatment Program as defined in HFS 40.04 Wis. Adm. Code.
  3. A certified AODA Day Treatment Program as defined in HFS 75.12(1) and (2) Wis. Adm. Code.
  4. A certified Community Support Program as defined in HFS 63.03 Wis. Adm. Code.
  5. A certified Residential AODA Treatment Program as defined in HFS 75.14(1) and (2) Wis. Adm. Code.
  6. Intensive outpatient programs for the treatment of substance abuse disorders provided in accordance with the criteria established by the American Society of Addiction Medicine.
  7. Services provided by a program certified under HFS 34.03 and provided in accordance with subchapter III HFS 34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other Providers for stabilization.

Covered Services also include the following:

- **Dependent Student Benefit** - A Dependent Student attending a School located in Wisconsin is entitled to the outpatient services described above even though services are provided outside the Service Area, subject to the limitations described below. As used in this section:

  1. "Dependent Student" means a child Dependent Member who is enrolled in a School located in Wisconsin.
  2. "School" means a vocational, technical, or adult education school; a center or institution within the University of Wisconsin system; and any institution of higher education that grants a bachelor's or higher degree.

  The Provider must be located in Wisconsin and in reasonably close proximity to the School in which the Dependent Student is enrolled. The Plan may designate the Provider.

  If outpatient services are recommended in the clinical assessment described above, benefits will be paid for visits to an outpatient treatment facility or other Provider that is located in Wisconsin and in reasonably close proximity to the School in which the Dependent Student is enrolled.

Benefits will not be paid if the nature of the treatment recommended in the assessment will prohibit the Dependent Student from attending the School on a regular basis.

Benefits will not be paid under this section after the Dependent Student has terminated his or her enrollment in the School.

- **Court-Ordered Services** - Benefits are available for Medically Necessary Hospital services, Medical Services, and outpatient services for behavioral health or substance abuse treatment rendered to a Member pursuant to an emergency detention, an involuntary commitment, or a court order to the extent benefits would have been available under this Benefit Booklet.

  Should such services not be rendered by a Network Provider, We will cover benefits to the extent benefits would have been available at the Network Level when:

  1. Services could not have been provided through a Provider selected by Us; and
  2. The Provider or Member, or other person on behalf of the Member, notifies Us within seventy-two (72) hours of the initial provision of such services.

  Upon receipt of such notification, We will arrange for further Medically Necessary services to be furnished by a Network Provider, if you wish benefits to be continued to be paid at the Network Level.

  You may also choose to continue to see Non-Network Providers, but further Medically Necessary services furnished by a Non-Network Provider will be paid at a lower level as indicated in the Schedule of Benefits.

  Reimbursement for services rendered by a Non-Network Providers will be no more than the maximum reimbursement for the services under the state medical assistance program.

Childhood Immunizations

Please see the "Preventive Care Services" provision later in this section for details. Also refer to the Schedule of Benefits for payment information.

Chiropractor Services

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

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

Non-Covered Services for chiropractic care include, but are not limited to:

- Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
- Nutritional or dietary supplements, including vitamins.
- Cervical pillows.

- Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

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 Benefit Booklet. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

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

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

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

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

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

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

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

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

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

Dental Services

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

Related to Accidental Injury

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury, unless the chewing or biting results from a medical or mental condition. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

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

- Oral examinations.
- X-rays.
- Tests and laboratory examinations.
- Restorations.
- Prosthetic services.
- Oral surgery.
- Mandibular / maxillary reconstruction.
- Anesthesia.

Other Dental Services

Hospital or Ambulatory Surgical Facility charges and anesthetics provided for dental care are covered if the Member meets any of the following conditions:

1. The Member is under the age of nineteen (19);

2. The Member has a chronic disability that is attributable to a mental and/ or physical impairment which results in substantial functional limitation in an area of the Member's major life activity, and the disability is likely to continue indefinitely; or
3. The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Diabetes Equipment, Education, and Supplies

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

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this section. For information on Prescription Drug coverage, please refer to the "Prescription Drugs" provision in this section. Screenings for gestational diabetes are covered under "Preventive Care."

Diagnostic Services

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

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.

- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

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

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

When Diagnostic radiology is performed in a Network Physician's Office, no Copayment is required. Any Coinsurance from a Network or a Non-Network Physician will still apply.

Emergency Care and Urgent Care Services

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

Emergency Care (including Emergency Room Services)

Benefits are available for services or supplies that you require in the emergency room to treat an Emergency. If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital.

Medically Necessary services that meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible.

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

1. The amount negotiated with Network Providers for the emergency service furnished;
2. The amount for the emergency service calculated using the same method We generally use to determine payments for Non-Network services but substituting the Network cost-sharing provisions for the Non-Network cost-sharing provisions; or
3. The amount that would be paid under Medicare for the emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

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

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copayment/Coinsurance for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours, or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have contract with Us or is a BlueCard Provider, you will be financially responsible for any care determined to be not Medically Necessary.

Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as a Non-Network service unless the continuation of care is authorized and is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment that cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician directs you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

See your Schedule of Benefits for benefit limitations.

Home Care Services

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

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

- Evaluation of the need, and development of a plan, for home care by a registered nurse (R.N.), a physician extender, or medical social worker when approved or requested by the attending Physician.
- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.).
- Medical/Social Services.
- Diagnostic Services.
- Nutritional counseling provided by or under the supervision of a registered dietician or a dietician certified under subch. IV of chap. 448 when Medically Necessary as part of the home care plan; and
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when allowed by the Plan, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services. Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).
- Private Duty Nursing.

Non Covered Services include but are not limited to:

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

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

Home infusion therapy Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

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

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

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

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

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

Inpatient Services

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

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF), or other Provider for room, board, and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit allowed by the Plan. The unit must have facilities, equipment, and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms, and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts, and splints.
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care for** constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exam** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

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

Kidney Disease Treatment

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

Benefits are available for kidney disease treatment including dialysis, transplantation, and donor-related services.

Note: Members with End Stage Renal Disease (ESRD) should contact Medicare about enrollment and benefit options.

Lead Poisoning Screening

Please see the "Preventive Care Services" provision later in this section for details. Also refer to the Schedule of Benefits for payment information.

Mammography Examinations

Please see the "Preventive Care Services" provision later in this section for details. Also refer to the Schedule of Benefits for payment information.

Maternity Services

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

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a Provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

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

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

Under federal law, the Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than forty-eight (48) hours following vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours, or ninety-six (96) hours, as applicable. In any case, as provided by federal law, the Plan may not require that a Provider obtain authorization before prescribing a length of stay which is not in excess of forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours following a cesarean section.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

    1. The antepartum, intrapartum, and postpartum course of the mother and infant;
    2. The gestational stage, birth weight, and clinical condition of the infant;
    3. The demonstrated ability of the mother to care for the infant after discharge; and
    4. The availability of postdischarge follow-up to verify the condition of the infant after discharge.

- **Covered Services include at-home post delivery care visits** at your residence by a Physician or Nurse following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

    1. Parent education;
    2. Assistance and training in breast or bottle feeding; and

3. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

- At your discretion, this visit may occur at the Physician's office.

Medical Supplies, Durable Medical Equipment, and Appliances

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

The supplies, equipment, and appliances described below are Covered Services under this benefit. If the supplies, equipment, and appliances include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

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

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).
- In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1. The equipment, supply, or appliance is worn out or no longer functions.
2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4. The equipment, supply, or appliance is damaged and cannot be repaired.

Benefits for repairs and replacement do *not* include the following:

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

The Plan may establish reasonable quantity limits for certain supplies, equipment, or appliances described below.

Covered Services may include, but are not limited to:

- **Medical and surgical supplies** – Certain supplies and equipment for the management of disease that are allowed by the Plan are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have the Plan's Prescription Drug benefit or if the supplies, equipment, or appliances are not received from the PBM's Mail Service or from a Network Pharmacy. These include: Syringes, needles, oxygen, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to, Depo-Provera. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:

  1. Allergy serum extracts
  2. Chem strips, Glucometer, Lancets
  3. Clinitest
  4. Needles/syringes
  5. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

  Non Covered Services include but are not limited to:

  1. Adhesive tape, band aids, cotton tipped applicators
  2. Arch supports
  3. Doughnut cushions
  4. Hot packs, ice bags
  5. Vitamins
  6. Medijectors
  7. Elastic stockings or supports
  8. Gauze and dressings

  The exclusion listed above does not apply to:

  - Supplies necessary for the effective use of Durable Medical Equipment,
  - Diabetic supplies.

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

- **Durable medical equipment** - The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service

only when the equipment is a rental, and medically fitting supplies are included in the rental. If the Member owns the equipment, medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

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

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

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

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

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

  1. Replace all or part of a missing body part and its adjoining tissues; or
  2. Replace all or part of the function of a permanently useless or malfunctioning body part.

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

  Covered Services may include, but are not limited to:

  1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2. Left Ventricular Artificial Devices (LVAD).

3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implants for children and adults. See further information below, regarding additional hearing benefits for children under age 18.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

Hearing Aids, Cochlear Implants, and Related Treatment for Children under the Age of 18: Benefits are available for hearing aids, cochlear implants, and related treatment for children under the age of 18 who are certified as deaf or hearing impaired by either a Physician or audiologist licensed under Wisconsin law. Related treatment includes services, diagnoses, surgery, and therapy provided in connection with the hearing aid and/or cochlear implant.

Coverage of hearing aids is subject to the limit listed in the "Schedule of Benefits." Please note that Covered Services do not include the cost of batteries or cords.

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury.
7. Routine periodic servicing, such as testing, cleaning, and checking of the device.

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

- **Orthotic devices** – Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable

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

Covered orthotic devices may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.
5. Routine periodic servicing, such as testing, cleaning, and checking of the device.

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

Nurse Practitioner Services

Benefits are available for Papanicolaou tests (pap smears), pelvic examinations, and associated diagnostic services provided by a licensed Nurse Practitioner if benefits are available for the services when provided by a Physician. The Nurse Practitioner must be practicing within the scope of his or her license in order for benefits to be covered.

Outpatient Services

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

Outpatient Services include facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as allowed by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or

rehabilitation, or other Provider facility as allowed by the Plan. Professional charges only include services billed by a Physician or other professional.

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

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

Physician Home Visits and Office Services

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

Covered Services include care provided by a Physician in their office or your home.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections, and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

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

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

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

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

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

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

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

Preventive Care Services

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

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

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

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Covered Services include screenings for:
    a. Breast cancer,
    b. Cervical cancer,
    c. Colorectal cancer,
    d. High blood pressure,
    e. Type 2 Diabetes Mellitus,
    f. Cholesterol,
    g. Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a. Women's contraceptives, sterilization procedures, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary according to your attending Provider, otherwise they will be covered under the Prescription Drug benefit.
    b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
    c. Gestational diabetes screening.
5. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
    a. Counseling
    b. Prescription Drugs

c. Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

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

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

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

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

You may call Member Services using the number on your ID card for additional information about these services or view the federal government's web sites, https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

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

- Lead poisoning screening for children.
- Routine mammograms.
- Appropriate and necessary childhood immunizations that meet the standards approved by the U.S. public health service for such biological products against at least all of the following:

  1. Diphtheria,
  2. Pertussis,
  3. Tetanus,
  4. Polio,
  5. Measles,
  6. Mumps,
  7. Rubella,
  8. Hemophilus influenza b (Hib),
  9. Hepatitis B,
  10. Varicella.

  (Additional immunizations will be covered per federal law, as indicated earlier in this section.)

- Routine colorectal cancer examinations and laboratory tests.

Other Covered Services include:

- Routine vision screening.
- Routine hearing screening.

Surgical Services

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

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Other procedures as allowed by the Plan.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

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

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

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

Reconstructive Services

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

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

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy and who elects breast reconstruction, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Sterilization

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

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

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

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders. Covered Services include diagnostic procedures and Medically Necessary surgical or non-surgical treatment. Benefits are also available for prescribed intraoral splint therapy devices.

Therapy Services

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

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury,

or loss of a body part. **Non-Covered Services** include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). **Non-Covered Services** include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning, and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment, which may include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

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

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

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

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

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

Vision Services

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

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

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services

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

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

- **Cornea and kidney transplants; and**

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

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

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and transfusions as allowed by the Plan including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

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

Prior Approval and Precertification

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

Precertification is required before the Plan will cover benefits for a transplant. Your Physician must certify, and We, on behalf of the Employer, must agree, that the transplant is Medically Necessary. Your Physician should submit a written request for precertification to Us as soon as possible to start this process. Failure to obtain precertification will result in a denial of benefits.

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

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

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

- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically allowed by the Plan,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Interim visits to a medical care facility while waiting for the actual transplant procedure,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

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

Prescription Drugs Administered by a Medical Provider

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

This Plan covers Prescription Drugs, including Specialty Drugs that must be administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and

a medical Provider administers it to you in a medical setting. Benefits for Drugs that you inject or get through your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Provider may be asked to give more details before we can determine if the Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug or a Drug regimen or another treatment be used prior to use of another Drug or Drug regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another,
- Use of an Anthem Prescription Drug List (a formulary developed by Anthem) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. We will give the results of our decision to both you and your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section "Health Care Management" for more details.

If precertification is denied you have the right to file an appeal as outlined in the "Your Right to Appeal" section of this Booklet.

Designated Pharmacy Provider

Anthem in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. A Network

Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with Anthem. You or your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider's office, you and your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider's office.

The Plan may also require you to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. We reserve our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. Anthem may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in our discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Non-Network level.

You can get the list of the Prescription Drugs covered under this section by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Providers about alternatives to certain prescribed Drugs. We may contact you and your Provider to make you aware of these choices. Only you and your Provider can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Prescription Drug Benefits at a Retail or Home Delivery (Mail Order) Pharmacy

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

Please note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you by a medical Provider in a medical setting (e.g., doctor's office visit, home care visit, or outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy.

The pharmacy benefits available to you under the Plan are managed by Our pharmacy benefits manager (PBM). The PBM is a pharmacy benefits management company with which We contract to manage your pharmacy benefits. Our PBM has a nationwide network of retail pharmacies, a Home Delivery (Mail Service), a Specialty pharmacy, and provides clinical management services.

The management and other services Our PBM provides include, among others, making recommendations to, and updating, the covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies operating a Mail Service pharmacy, and a Specialty Drug Pharmacy Network. Our PBM, in consultation with Us, also provides services to promote and enforce

the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

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

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

Prescription Drug benefits may require prior authorization to determine if your Drugs should be covered. Your Network Pharmacist will be told if Prior Authorization is required and if any additional details are needed for us to decide benefits.

Prior Authorization

Prescribing Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug or a Drug regimen or another treatment be used prior to use of another Drug or Drug regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another.
- Use of a Prescription Drug List (as described below).

You or your Provider can get the list of the Drugs that require prior authorization by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in our sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

If prior authorization is denied you have the right to file an appeal as outlined in the "Your Right to Appeal" section of this Booklet.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your doctors about alternatives to certain prescribed Drugs. We may contact you and your doctor to make you aware of these choices. Only you and your doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Identification Card.

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time. You or your doctor may be required to order certain Specialty Drugs from the PBM's Specialty Pharmacy.

When you use the PBM's Specialty Pharmacy, its patient care coordinator will work with you and your doctor to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Covered Prescription Drug Benefits

Covered Services include Prescription legend drugs which:

1. May only be dispensed according to a written Prescription from a Physician, under federal law;
2. Are approved for human use by the Food and Drug Administration; and
3. Are dispensed by a Pharmacist, acting within the scope of his/her license, on or after your Effective Date for your outpatient use.

Covered Services also include any Prescription legend drug that is:

1. Approved by the Food and Drug Administration for the treatment of HIV infection or HIV-related illness;
2. In or has completed a phase 3 clinical investigation; and
3. Prescribed and administered in accordance with the treatment protocol approved for the drug.

Covered services further include:

- Specialty Drugs.

- Medical supplies for the treatment of diabetes including insulin, blood glucose testing strips, lancets, insulin syringes, and test solutions. Benefits are also available for other Prescription Drugs used to treat diabetes.

  Equipment for the treatment of diabetes including glucometers, insulin infusion pumps and dedicated insulin infusion pump supplies, or related supplies is covered under the "Medical Supplies, Durable Medical Equipment, and Applicances" provision earlier in this section.

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

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

- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;

- Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. Benefits include FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These services will be covered under the "Preventive Care" benefit. Please see that section for further details.

- Oral chemotherapy Drugs. As required by Wisconsin law, your maximum Copayment will not be more than $100 per Prescription for a 30-day supply.

- Immunizations (including administration) required by the "Preventive Care Services" benefit.

- Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved and require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

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

- Prescription Drugs dispensed by any Mail Service program other than the PBM's Mail Service, unless prohibited by law.

- Prescription Drugs that are Experimental / Investigative. This Exclusion does not apply to any prescription legend drug that is:

  a. Approved by the Food and Drug Administration for the treatment of HIV infection or HIV-related illness;

b. In or has completed a phase 3 clinical investigation; and

c. Prescribed and administered in accordance with the treatment protocol approved for the drug.

- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents, and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This Exclusion does not apply to over-the-counter products that the Plan must cover as a "Preventive Care Services" benefit under federal law with a Prescription.
- Off label use, except as otherwise prohibited by law or as allowed by the Plan.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug that is used primarily for weight loss.
- Drugs not requiring a Prescription by federal law (including Drugs requiring a Prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities that exceed the limits established by the Plan including any age limits.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Compound Drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- Treatment of Onychomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact Us for additional information on these Drugs.
- Prescription Drugs or other services dispensed to you for purposes other than your own use.

- Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. "Clinically equivalent" means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. If you have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on the back of your Identification Card, or visit the Administrator's website at www.anthem.com.

  If you or your Physician believe you require continued coverage for a certain Prescription Drug, please have your Physician or Pharmacist contact the Administrator or the PBM. The Plan will cover your current Prescription Drug only if the Plan or the PBM agrees that it is Medically Necessary and appropriate over its clinically equivalent alternative. Continued coverage of the Prescription Drug will be subject to periodic review by the Administrator, on behalf of the Employer.

- Refills of lost or stolen medications.

- Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications, as determined by Anthem.

- Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Deductible/Coinsurance/Copayment

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

Days Supply

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

Tiers

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

- Tier 1 Prescription Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred medications that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 2 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred medications that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.
- Tier 3 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
- Tier 4 Prescription Drugs will have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products or multi-source Brand Drugs.

Tier and Formulary Assignment Process

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

The determinations of tier assignments and formulary inclusion are made by Us based upon clinical decisions provided by the National P&T Committee, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; generic availability, the degree of utilization of one Drug over another in Our patient population, and where appropriate, certain clinical economic factors.

We, on behalf of the Employer, determine coverage for dosage formulations in terms of covered dosage administration methods (for example, oral, injections, topical, or inhaled) and may cover one form of administration and exclusion or place other forms of administration in another tier.

Special Programs

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

Half-Tablet Program

The Half-Tablet Program will allow Members to pay a reduced Copayment on selected "once daily dosage" medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take "$\frac{1}{2}$ tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member's

decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact the number on the back of your ID Card.

Split Fill Dispensing Program

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

Payment of Benefits

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

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

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

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

How to Obtain Prescription Drug Benefits

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

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

Important Note: If it is determined that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, the Plan may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single Network Pharmacy. We will contact you if it is determined that use of a single Network Pharmacy is needed and give you options as to which Network Pharmacy you may use. If you do not select one of the Network Pharmacies we offer within 31 days, we will select a single Network Pharmacy for you. If you disagree with this decision, you may file an appeal as outlined in the "Your Right to Appeal" section.

Specialty Drugs – You or your Physician can order your Specialty Drugs directly from a Specialty Network Pharmacy, simply call 1-800-870-6419. If you or your Physician orders your Specialty Drugs from a Specialty Network Pharmacy, you will be assigned a patient care coordinator who will work with you and your Physician to obtain Prior Authorization and to coordinate the shipping of your Specialty Drugs directly to you or your Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your Specialty Drug Prescription.

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

- Name and address of the Non-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the Drug;
- Cost of the prescription;
- Quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Plan's Maximum Allowable Amount.

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

6 NON COVERED SERVICES/EXCLUSIONS

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

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

1. Which We, on behalf of the Employer, determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

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

13. Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
14. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
15. For missed or canceled appointments.
16. For mileage, lodging and meals costs, and other Member travel related expenses, except as allowed by the Plan or specifically stated as a Covered Service.
17. For which benefits are payable under Medicare Part A and/or Medicare Part B, or would have been payable if a Member had applied for Parts A and/or B, except, as specified elsewhere in this Benefit Booklet or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For purposes of the calculation of benefits, if the Member had not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.
18. Charges in excess of the Plan's Maximum Allowable Amounts.
19. Incurred prior to your Effective Date.
20. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
21. For any procedures, services, Prescription Drugs, equipment, or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change, or improve your appearance or are furnished for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by Us on behalf of the Employer, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier / self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including, but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
22. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
23. The Plan does not pay services supplies etc for:
    a. Custodial Care, convalescent care or rest cures.
    b. Domiciliary care provided in a residential institution, treatment center, supervised living or halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    c. Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

d. Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, residential programs for drug and alcohol, halfway house, or outward bound programs, even if psychotherapy is included.

e. Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

24. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:

- Cleaning and soaking the feet.
- Applying skin creams in order to maintain skin tone.
- Other services that are performed when there is not a localized illness, injury or symptom involving the foot.

25. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

26. For dental treatment, regardless of origin or cause, except as specified elsewhere in this Benefit Booklet. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

- Extraction, restoration, and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

27. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

28. For Dental implants.

29. For Dental braces.

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

- Transplant preparation.
- Initiation of immunosuppresives.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.

31. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

32. Weight loss programs whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Benefit Booklet.

    This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.

33. 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 Us, on behalf of the Employer, 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 Member 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.
34. For marital counseling.
35. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
36. For vision orthoptic training.
37. For hearing aids or examinations for prescribing or fitting them. This exclusion does not apply to hearing aids or examinations required for children under age 18 who are receiving the benefits described in the “Covered Services” section.
38. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
39. For services to reverse voluntarily-induced sterility.
40. For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis.
41. For personal hygiene, environmental control, or convenience items including but not limited to:
    a. Air conditioners, humidifiers, air purifiers;
    b. Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals;
    c. Charges for non-medical self-care except as otherwise stated;
    d. Purchase or rental of supplies for common household use, such as water purifiers;
    e. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    f. Infant helmets to treat positional plagiocephaly;
    g. Safety helmets for Members with neuromuscular diseases; or
    h. Sports helmets.
42. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or allowed by the Plan.

43. For care received in an emergency room that is not Emergency Care, except as specified in this Benefit Booklet. This includes, but is not limited to, suture removal in an emergency room.
44. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.
45. For self-help training and other forms of non-medical self care, except as otherwise provided herein.
46. For examinations relating to research screenings.
47. For stand-by charges of a Physician.
48. Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.
49. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
50. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
51. Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
52. For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.
53. Nutritional and/or dietary supplements, except as provided in this Benefit Booklet or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
54. For 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 and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, and electromagnetic therapy.
55. For any services or supplies provided to a person not covered under the Benefit Booklet in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
56. For surgical treatment of gynecomastia.
57. For treatment of hyperhidrosis (excessive sweating).
58. For any service for which you are responsible under the terms of this Benefit Booklet to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

59. Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.

60. Services, supplies, and equipment for the following:

    a. Gastric electrical stimulation.
    b. Hippotherapy.
    c. Intestinal rehabilitation therapy.
    d. Prolotherapy.
    e. Recreational therapy.
    f. Sensory integration therapy (SIT).

61. Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

62. Complications directly related to a service or treatment that is a non Covered Service under this Benefit Booklet because it was determined by Us, on behalf of the Employer, to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

63. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply. This Exclusion does not apply to over-the-counter products that we must cover as a “Preventive Care Services” benefit under federal law with a Prescription.

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

65. Treatment of telangiectatic dermal veins (spider veins) by any method.

66. The following allergy tests and treatment:

    a. IgE RAST tests unless intradermal tests are contraindicated.
    b. Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    c. Food allergy test panels (including SAGE food allergy panels).
    d. Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

67. Reconstructive services except as specifically stated in the "Covered Services" section of this Benefit Booklet, or as required by law.

68. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

69. For room and board charges unless the treatment provided meets Our Medical Necessity criteria for Inpatient admission for your condition.

70. For routine vision screenings not required by federal law as described in the "Preventive Care" benefit.

71. Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described under “Autism Services” in the “Covered Services” section unless otherwise required by law.

72. Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center.

73. Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

    If you or your Physician believes you need to use a different Prescription Drug, please have your Physician or pharmacist get in touch with us. The Plan will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

74. Charges for delivery of Prescription Drugs.

75. Drugs in quantities which are over the limits set by the plan, or which are over any age limits set by us.

76. Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.

77. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications, as determined by Anthem.

78. Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

79. Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

80. Refills of lost or stolen Drugs.

81. Off label use, unless we must cover it by law or if we approve it.

7 ELIGIBILITY AND ENROLLMENT

You have coverage provided under the Plan because of your employment with / membership with / retirement from the Employer. You must satisfy certain requirements to participate in the Plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by Your Employer or state and/or federal law and allowed by the Plan.

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

Eligibility

The following eligibility rules apply unless you are notified by Us and the Employer.

Subscriber

To be eligible to enroll as a Subscriber, an individual must:

- Be either: An employee, member, or retiree of the Employer, and:
- Be entitled to participate in the benefit Plan arranged by the Employer;
- Have satisfied any probationary or waiting period established by the Employer and (for non-retirees) be Actively At Work performing the duties of your principal occupation for the Employer at least thirty (30) hours per week.
- Reside or work in the Service Area

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Employer and be:

- The Subscriber's spouse. For information on spousal eligibility please contact the Employer.
- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children and children who the Employer has determined are covered under a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.
- Children for whom the Subscriber or the Subscriber's spouse is a legal guardian or as otherwise required by law.
- A child of a covered Dependent (i.e., a grandchild of the covered Subscriber or the Subscriber's covered spouse) until the Dependent child reaches age eighteen (18).

All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits.

Coverage will be continued past the age limit in either of the following circumstances:

- For those already enrolled unmarried Dependents who cannot work to support themselves due to mental retardation or physical handicap. The Dependent's disability must start before the end of the period they would become ineligible for coverage. The Plan must be informed of the Dependent's eligibility for continuation of coverage within thirty-one (31) days after the Dependent would normally become ineligible. You must then provide proof as often as the Plan requires. This will not be more often than once a year after the two (2) year period following the child reaching the limiting age. You must provide the proof at no cost to the Plan. You must notify Us or the Employer if the Dependent's marital status changes and they are no longer eligible for continued coverage.

- For an unmarried Dependent child who was called to active duty in the National Guard or in a reserve component of the United States armed forces prior to age 27 and is currently a full-time student, regardless of age. The Dependent child cannot be eligible for coverage under his/her employer's group health plan unless the Fee for that coverage is greater than the Fee charged for a Dependent under this Benefit Booklet. Coverage will end when the child ceases to be a full-time student, marries, or becomes eligible for a group health plan for which the Fee is less than the Fee charged a Dependent under this Benefit Booklet.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

To obtain coverage for children, the Plan may require that the Subscriber complete a "Dependency Affidavit" and provide a copy of any legal documents awarding guardianship of such child(ren) to the Subscriber. Temporary custody is not sufficient to establish eligibility under the Plan.

Note: Any Dependent children of the Subscriber who reside outside the Service Area (such as college students) who wish to receive Network benefits must obtain Hospital and medical services from a Network Provider, with the exception of Emergency services and outpaitient behavioral health and substance abuse services as described in the "Covered Services" section.

Coverage of Dependent Students on Medical Leave

The information below applies to Dependent students who were called to active duty in the National Guard or in a reserve component of the United States armed forces prior to age 27 and have now returned to school on a full-time basis.

If, while covered under this Benefit Booklet, a Dependent student needs to reduce his/her course load or leave school due to a Medically Necessary leave of absence, the Dependent student may be eligible to continue coverage under this Benefit Booklet.

We may require documentation of the Medical Necessity of the leave of absence from the Dependent's attending Physician. The date on which the Dependent ceases to be a full-time student due to the Medically Necessary leave of absence shall be the date on which the continuation of coverage begins.

Coverage will continue until any of the following occurs:

1. We are advised that the Dependent does not intend to return to school full time.
2. The Dependent becomes employed full time.
3. The Dependent obtains other health care coverage.
4. The Dependent marries and is eligible for coverage under his or her spouse's health care coverage.
5. Coverage of the Member through whom the person has Dependent coverage under this Benefit Booklet is discontinued or not renewed.
6. One year has elapsed since the Dependent's continuation of coverage began and the Dependent has not returned to school full time.

Enrollment

Initial Enrollment

An Eligible Person can enroll for Single or Family Coverage by submitting an application to Us. The application must be received within thirty-one (31) days of the Subscriber's initial eligibility. Your Effective Date will be the first of the month following the date you complete any probationary period required by the Employer. The probationary / waiting period will not exceed 90 days. If We do not receive the initial application within thirty-one (31) days of initial eligibility, the Eligible Person can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

If a person qualifies as a Dependent but does not enroll when the Eligible Person first applies for enrollment, the Dependent can only enroll for coverage during the Open Enrollment period or during a Special Enrollment period, whichever is applicable.

It is important for you to know which family members are eligible to apply for benefits under Family Coverage. See the section on Eligible Dependents.

Continuous Coverage

If you were covered by the Employer's prior carrier or plan immediately prior to the Employer's agreement with Us, with no break in coverage, then you will receive credit for any accrued Deductible and, if applicable and allowed by the Plan, Out of Pocket amounts under that other plan. This does not apply to persons who were not covered by the prior carrier or plan on the day before the Employer's coverage began, or to persons who join the Employer later.

If your Employer moves from one of the plans We administer to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately prior to enrolling in this product with no break in coverage, then you may receive credit for any accrued Deductible and Out of Pocket amounts, if applicable and allowed by the Plan. Any maximums when applicable, will be carried over and charged against the maximums under the Plan.

If your Employer offers more than one product We administer, and you change from one product to another with no break in coverage, you will receive credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums.

If your Employer offers coverage through other products or carriers in addition to the plans We administer, and you change products or carriers to enroll in this product with no break in coverage, you will receive credit for any accrued Deductible, Out of Pocket, and any maximums.

This Section Does Not Apply To You If You:

- Change from one of Our individual policies to a group plan;
- Change employers; or
- Are a new Member who joins the Employer's Plan after the Employer's initial enrollment with Us.

Newborn Child Coverage

If Family Coverage is not already in force, your Dependent's Effective Date will be the date of birth, if you send the Plan the completed change form within thirty-one (31) days of the birth.

If Family Coverage is already in force, but additional Fees are required for the newborn Dependent, your Dependent's Effective Date will be the date of birth only if:

- You notify Us of the birth and pay the additional Fees within sixty (60) days of the birth, or
- You notify Us within one year of the birth, and pay all past due Fees plus interest at the rate of 5 1/2% per year.

Adopted Child Coverage

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

If Family Coverage is not already in force, your Dependent's Effective Date will be the date of the adoption or placement for adoption, if you send Us the completed change form within thirty-one (31) days of the event.

If Family Coverage is already in force, your Dependent's Effective Date will be the date of the adoption or placement for adoption. If, however, additional Fees are required for the adopted Dependent, your Dependent's Effective Date will be the date of the adoption or placement for adoption, only if you notify Us of the adoption and pay the additional Fees within sixty (60) days of the adoption.

Adding a Child due to Award of Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse is awarded legal custody or guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage would start on the date the court granted legal custody or guardianship. If the Plan does not receive an application within the 31-day period, the child will be treated as a Late Enrollee.

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child under the Plan, your child will be allowed to enroll at any time without regard to any Open Enrollment limits and shall receive the benefits of the Plan in accordance with the applicable requirements of such order.

Family Coverage under the Plan will be provided for the Member's child upon application by the Member, the child's other parent, the Department of Health and Family Services or the county designee under Wis. Stat. § 59.53 (5).

After the child is covered under the Plan, and as long as the Member is eligible for Family Coverage under the Plan coverage for the child will continue unless We or the Employer receive satisfactory written evidence that the court order is no longer in effect or that the child has coverage under another group policy or individual policy that provides comparable health coverage.

If coverage is provided under the Plan for a child of a Member who is not the custodial parent of the child, the Plan shall do all of the following:

- Provide to the custodial parent of the child information related to the child's enrollment;

- Permit the custodial parent of the child, a health care Provider that provides services to the child, or the Department of Health and Family Services to submit claims for benefits without the approval of the parent who is the Member; and
- Pay claims directly to the health care Provider, the custodial parent of the child, or the Department of Health and Family Services as appropriate.

A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits.

Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage (including Medicaid), you may in the future be able to enroll yourself or your Dependents in the Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your other coverage ends (or within 60 days after Medicaid coverage ends) after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage),. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If We receive an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, We will not be able to enroll that person until the Employer's next Open Enrollment. Application forms are available from the Employer.

BadgerCare

If the Wisconsin Department of Health and Family Services agrees to purchase coverage under this Benefit Booklet for you in lieu of enrolling you in the Medical Assistance Program (under s. 49.472, Wis. Stat.), Badger Care (under s. 49.665, Wis. Stat.), or BadgerCare Plus (under s. 49.471, Wis. Stat.), you will have 60 days from the date of that determination to apply for this coverage. If we receive your completed application within 60 days, We will enroll you on the first of the month following Our receipt of the application.

Open Enrollment Period

An Eligible Person or Dependent who did not request enrollment for coverage during the initial enrollment period, or during a Special Enrollment period, may apply for coverage at any time, however, will not be enrolled until the Employer's next annual enrollment.

Open Enrollment means a period of time (at least 31 days prior the Employer's renewal date and 31 days following) which is held no less frequently than once in any 12 consecutive months.

Notice of Changes

The Subscriber is responsible for notifying the Employer of any changes that will affect his or her eligibility or that of Dependents for services or benefits under the Plan. The Plan must be notified of any

changes as soon as possible but no later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another health plan or Medicare. Failure to notify Us of persons no longer eligible for services will not obligate the Plan to pay for such services. Acceptance of payments from the Employer for persons no longer eligible for services will not obligate the Plan to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications by the Employer must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

A Member's coverage terminates on the last day of the billing period in which the Member ceases to be in a class of Members eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

Nondiscrimination

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

Effective Date of Coverage

You will not be covered by the Plan until your Effective Date. Unless the Plan states otherwise, the Subscriber must be Actively at Work on the day his / her coverage is to become effective.

If you apply for Family Coverage with your own application, the Effective Date for your Dependents will be the same as your Effective Date. If you apply for coverage for your Dependents at a different time, their Effective Dates will differ.

Statements and Forms

Subscribers (or applicants for membership) must complete and submit applications, medical review questionnaires, or other forms or statements the Plan may reasonably require.

Applicants for membership understand that all rights to benefits under the Plan are subject to the condition that all such information is true, correct, and complete. Any material misrepresentation by a Member may result in termination of coverage as provided in the "Changes in Coverage: Termination & Continuation " section. The Plan will not use a statement made by a Member to void the Member's contract after coverage has been in effect for two (2) years. This does not apply, however, to fraudulent misstatements.

Delivery of Documents

We will provide an Identification Card for each Member and a Benefit Booklet for each Subscriber.

8 CHANGES IN COVERAGE: TERMINATION & CONTINUATION

Termination

Except as otherwise provided, your coverage may terminate in the following situations.

- Your coverage will terminate on the date the Administrative Services Agreement between the Employer and Us terminates. If your coverage is through an association, your coverage will terminate on the date the Administrative Services Agreement between the association and Us terminates, or on the date your Employer leaves the association. It will be the Employer's / association's responsibility to notify you of the termination of coverage.
- If you terminate your coverage, termination will be effective on the last day of the billing period.
- Subject to any applicable continuation requirements, if you cease to meet eligibility requirements as outlined in the Plan, your coverage will terminate on last day of the billing period. If you cease to be eligible due to termination of employment, your coverage will terminate on the last day of the billing period you were employed by the Employer. You must notify the Employer and Us immediately if you cease to meet the eligibility requirements. You shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the plan, just as if you never had coverage under the plan. You will be provided with a thirty (30) calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying the Plan for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Fees paid for such services.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent, except when indicated otherwise in this Benefit Booklet.
- If you elect coverage under another carrier's health benefit plan which is offered by, through, or in connection with the Employer as an option instead of this plan, then coverage for you and your Dependents will terminate at the end of the billing period for which Fees have been paid, subject to the consent of the Employer. The Employer agrees to immediately notify Us that you have elected coverage elsewhere.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Fees, the Employer may terminate your coverage and may also terminate the coverage of all your Dependents.
- If you permit the use of your or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse the Plan for the Maximum Allowable Amount for services received through such misuse.

- If the Subscriber moves outside of the Service Area and the Subscriber's place of employment is not located within the Service Area, coverage terminates for the Subscriber and all covered Dependents at the end of the billing period that contains the date that Subscriber moves outside of the Service Area.

Removal of Members

Upon written request through the Employer, a Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Reinstatement

You will not be reinstated automatically if coverage is terminated, except as indicated below. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time your or the Employer's request for reinstatement is being considered by Us. Your coverage shall not be adversely affected due to the Employer's clerical error. However, the Employer is liable to Us if We incur financial loss as a result of the Employer's clerical error.

If you return to Active Work upon the completion of an FMLA leave period and you elect to have coverage reinstated or the Employer requires your coverage be reinstated, coverage will be reinstated on the date you return from FMLA leave. The benefits reinstated are the benefits that you and your Dependents would have received if coverage had been continuous.

Following a military leave, if you return or request re-employment within the statutory period, coverage will be reinstated on the date you return. Please see the section "Continuation of Coverage Due to Military Service" later in this section for further details.

Continuation

Federal Continuation of Coverage (COBRA)

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

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

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Employer's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, the Employer must offer COBRA continuation coverage to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Employer's health plan is

lost because of the qualifying event. Under the Employer's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Employer for payment requirements.

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

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

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

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

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

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

If Your Employer Offers Retirement Coverage

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

When is COBRA Coverage Available

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided

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

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the Subscriber, the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a covered Subscriber becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Employer's health plan is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Employer. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Subscriber or former Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Employer's health plan had the first qualifying event not occurred.

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

Fees and the End of COBRA Coverage

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

Continued coverage ends earlier if the plan ends or if the person covered:

- Fails to pay Fees timely;
- After the date of election, first becomes covered under another group health plan;
- After the date of election, first becomes entitled to Medicare benefits; or
- The Employer ceases to provide any group health plan for its employees.

Other Coverage Options Besides Cobra Continuation Coverage

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

If You Have Questions

Questions concerning your Employer's health plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group

health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended. Employers must provide a cumulative total of five (5) years, and in certain instances more than five (5) years, of military leave.

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

During a military leave covered by the Act, the law requires employers to continue to provide coverage under the Plan for its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents (if any) under the Plan by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During Military Leave

Continued coverage under USERRA will terminate on the earlier of the following events:

1) The date you fail to return to Active Work with the Employer following completion of your military leave. Employees must return to Active Work within:

    a. The first full business day after completing military service, for leaves of thirty (30) days or less. A reasonable amount of travel time will be allowed for returning from such military service.

    b. Fourteen (14) days after completing military service for leaves of thirty-one (31) to one hundred eighty (180) days,

    c. Ninety (90) days after completing military service, for leaves of more than one hundred eighty (180) days; or

2) Twenty-four (24) months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

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

1. The first full business day of completing your military service, for leaves of thirty (30) days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. Fourteen (14) days of completing your military service, for leaves of thirty-one (31) to one hundred eighty (180) days; or
3. Ninety (90) days of completing your military service, for leaves of more than one hundred eighty (180) days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to Active Work within the times stated above, you may take up to:

1. Two (2) years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two (2) years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any Probationary Periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, the Plan will not provide coverage for any illness or injury caused or aggravated by your military service, as indicated in the "Non-Covered Services / Exclusions" section.

Benefits After Termination Of Coverage

Any benefits available under this provision are subject to all the other terms and conditions of the Plan.

If you are Totally Disabled on the Employer's termination date, and you are not eligible for regular coverage under another similar health plan, benefits will continue for treatment of the disabling condition(s). Benefits will continue until the earliest of:

a. The date you cease to be Totally Disabled;

b. The end of a period of twelve (12) months in a row that follows the Employer termination date;

c. The date you become eligible for regular coverage under another health plan; or

d. The payment of any lifetime or benefit maximum.

Benefits provided to you under this continuation of benefits provision shall be limited to coverage for treatment of the condition or conditions causing Total Disability and shall in no event include coverage for any dental condition.

Family and Medical Leave Act of 1993

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

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work. To obtain coverage for a Subscriber upon return from leave under the Act, the Employer must provide evidence satisfactory to Us of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

9 HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Service from Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. Services you obtain from any Provider other than a PCP, SCP, or another Network Provider are considered a Non-Network Service, unless otherwise indicated in this Benefit Booklet. Contact Us to be sure that Prior Authorization and/or precertification has been obtained.

Network Services and Benefits

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

- **Network Providers** - include Primary Care Physicians (PCP), Specialty Care Physicians (SCP), other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The Primary Care Physician is the Physician who may provide, coordinate, and arrange your health care services. SCP's are Network Physicians who provide specialty medical services not normally provided by a PCP. Referrals are never needed to visit a Network Specialist including behavioral health Providers.

  To see a doctor, call their office:

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

  When you go to the office, be sure to bring your Member Identification Card with you.

  For services rendered by Network Providers:

1. You will not be required to file any claims for services you obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from the Plan and not from you except for approved Coinsurance, Copayments, and/or Deductibles. You may be billed by your Network Provider(s) for any non-Covered Services you receive or when you have not acted in accordance with the Plan.
2. Health Care Management is the responsibility of the Network Provider.

If a network is not available for a Covered Service (e.g., anesthesia services, dental services, and hospice services), benefits for that Covered Service will be paid at the Network level, subject to in-network Copayments / Deductibles / Coinsurance, up to the Plan's Maximum Allowable Amount. You may also be billed for charges that exceed the Plan's Maximum Allowable Amount. Please contact Us to determine if a Network Provider is available.

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.

Non-Network Services

Services which are not obtained from a PCP, SCP, or another Network Provider will be considered a Non-Network Service, unless otherwise indicated in this Benefit Booklet.

For services rendered by a Non-Network Provider, you are responsible for:

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

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

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

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard," which provides services to you when you are outside our Service Area. For more details on this program, please see "Inter-Plan Arrangements" in the "Claims Payment" section.

Relationship of Parties (Plan - Network Providers)

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

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under your plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

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

Not Liable for Provider Acts or Omissions

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

Identification Card

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

Continuity of Care

If a Network Provider who has provided Covered Services to you terminates his or her agreement with Us, please contact Our Member Services Department. We have procedures in place that will allow you to continue to see that Provider for a limited time. We can also assist you in selecting another Network Provider to provide your care.

10 CLAIMS PAYMENT

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

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

How Benefits Are Paid

Maximum Allowed Amount

GENERAL

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

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

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

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

When You receive Covered Services from Provider, We 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 Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means We have 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, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those

procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

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

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

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

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

1. An amount based on Our managed care fee schedules used with Network Providers, which We reserve the right to modify from time to time.; 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, Anthem 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 Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Non-Network Provider.

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

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

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

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

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by Us using prescription drug cost information provided by the Pharmacy Benefits Manager.

MEMBER COST SHARE

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

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

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

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

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

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

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

- *The Non-Network anesthesiologist's charge for the service is $1200. The Maximum Allowed Amount for the anesthesiology service is $950; Your Coinsurance responsibility is 20% of $950, or $190 and the*

remaining allowance from Us is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the Deductible has been met, your total Out of Pocket responsibility would be $190 (20% Coinsurance responsibility) plus an additional $250, for a total of $440.

- *You choose a Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; Your Coinsurance responsibility when a Network surgeon is used is 20% of $1500, or $300. We allow 80% of $1500, or $1200. The Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be $300.*

- *You choose a **NON-NETWORK** surgeon. The Non-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; Your Coinsurance responsibility for the NON-NETWORK surgeon is 30% of $1500, or $450 after the NON-NETWORK Deductible has been met. We allow the remaining 70% of $1500, or $1050. **In addition**, the Non-Network surgeon could bill You the difference between $2500 and $1500, so your total Out of Pocket charge would be $450 plus an additional $1000, for a total of $1450.*

AUTHORIZED SERVICES

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

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

Example:

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

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

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

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

Payment of Benefits

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

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

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 Maximum Allowable Amount. If services are performed by Non-Network Providers, then you are responsible for any amounts charged in excess of the Maximum Allowable Amount. Contact Us for more information.

Assignment

The Employer cannot legally transfer this Benefit Booklet, without obtaining written permission from Us. Members cannot legally transfer the coverage. Benefits available under this Benefit Booklet are not assignable by any Member without obtaining written permission from Us, unless in a way described in this Benefit Booklet.

Claims Review

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

Notice of Claim & Proof of Loss

This Plan is not liable, unless We receive written notice that Covered Services have been given to you. The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, either send a written request for claim forms to Us, or contact Member Services and ask for claim forms to be sent to you. If you do not receive the claim forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

Member's Cooperation

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

Explanation of Benefits (EOB)

After you receive medical care, you will generally receive an explanation of benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received.
- The amount of the charges satisfied by your coverage.
- The amount for which you are responsible (if any).
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Inter-Plan Arrangements

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you

access healthcare services outside the geographic area we serve (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

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

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care

Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Employer on your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

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

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

E. Nonparticipating Providers Outside Our Service Area

1. **Allowed Amounts and Member Liability Calculation**

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

2. **Exceptions**

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

F. BlueCard Worldwide® Program

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

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

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

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

How Claims are Paid with BlueCard Worldwide

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

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

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

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

When you need BlueCard Worldwide claim forms you can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bluecardworldwide.com.

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

11 HEALTH CARE MANAGEMENT

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

Certain Services must be reviewed to determine Medical Necessity in order for you to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem, on behalf of the Employer, may decide that a service that was asked for is not Medically Necessary if you have not tried other treatments that are more cost effective.

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

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

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

Types of Review:

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

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

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

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

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

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

Who is Responsible for Precertification?

Typically, Network Providers know which services require Precertification and will obtain any required Precertification when needed. Your Primary Care Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. Generally, the ordering Provider, facility or attending Physician ("requesting Provider") will contact us to request a Precertification. However, you may request a Precertification or you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	• The Provider must get Precertification when required.
Out of Network / Non-Participating	Member	• Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.

Provider Network Status	Responsibility to Get Precertification	Comments
Blue Card Provider	Member **(Except for Inpatient Admissions)**	• The Member must get Precertification when required. (Call Member Services.) • Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. • **Blue Card Providers must obtain precertification for all Inpatient Admissions.**
NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Physician must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.		

How Decisions are Made

We will utilize our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to assist in making Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider". These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically.

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

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

Decision and Notification Requirements

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

Request Category	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request

Urgent Concurrent / Continued Stay Review when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Urgent Concurrent / Continued Stay Review when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-Urgent Concurrent / Continued Stay Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

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

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

Important Information

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

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

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

You may find out whether a Provider is taking part in certain programs or a Provider arrangement by contacting the Member Services number on the back of your ID card.

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

Health Plan Individual Case Management

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

Our Case Management programs are confidential and voluntary and are made available at no extra cost to You. These programs are provided by, or on behalf of and at the request of, Your health plan case management staff. These Case Management programs are separate from any Covered Services You are receiving

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

In addition, We 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. We will make any recommendation to the Plan for alternate or extended benefits on a case-by-case basis, if in our discretion the alternate or extended benefit is in the best interest of you and the Plan and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to provide the same benefits again to you or to any other Member. The Plan reserves the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your authorized representative in writing.

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by Your Employer to help you achieve Your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under your Plan and could be discontinued at any time. If your Employer has selected one of these options to make available to all Employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options an Employer may select, You may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If You think You might be unable to meet the standard, You might qualify for an opportunity to earn the same reward by different means. You may contact Us at the Member Services number on Your ID card and We will work with You (and, if You wish, Your Physician) to find a wellness program with the same reward that is right for You in light of Your health status. (If You receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to You. For additional guidance, please consult Your tax advisor.)

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist You in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) within a specific timeframe. These

opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under this Benefit Booklet. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, You may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. (If You have any questions about whether receipt of a gift card or retailer coupon results in taxable income to You, we recommend that You consult Your tax advisor.

Value-Added Programs

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

12 YOUR RIGHT TO APPEAL

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card.

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

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

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

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

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

Notice of Adverse Benefit Determination

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

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

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

For claims involving urgent/concurrent care:

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

Appeals

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

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

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

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

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

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

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

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

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

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

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

If the Administrator fails to resolve the appeal with the required time, you may pursue external review as described later in this section. This option is not available, however, if the failure to resolve the appeal is due to a de minimus violation that does not cause harm to you or is not likely to cause prejudice or harm to you, if the delay is for good cause or due to matters beyond the Administrator's control, and is part of an ongoing, good faith exchange of information between you and the Administrator.

Voluntary Second Level Appeals

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

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

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

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

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name
- the service or supply for which approval of benefits was sought; and

- any reasons why the appeal should be processed on a more expedited basis.

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

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

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

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

Requirement to file an Appeal before filing a lawsuit

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

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

13 GENERAL PROVISIONS

Entire Agreement

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

Form or Content of Benefit Booklet

No agent or employee of Ours is authorized to change the form or content of this Benefit Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem Blue Cross and Blue Shield.

Allowable Amount Verification

You may contact Our Member Services Department prior to having a procedure performed to determine if the Provider's estimated charge is within the Plan's Maximum Allowable Amount and what your estimated out-of-pocket cost would be. You must provide Us with the following information:

1. The name of the Provider who will provide the service;
2. The name of the facility where services will be provided;
3. The date services will be provided;
4. The Provider's estimate of the charges; and
5. The codes for the service under the Current Procedural Terminology (CPT) or Current Dental Terminology (CDT).

Although We can assist you with this pre-service information, the final Maximum Allowable Amount and out-of-pocket cost will be based on the actual claim submitted by the Provider.

Care Coordination

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

Circumstances Beyond the Control of the Plan

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

Coordination of Benefits

When a Member is covered by two or more plans, We coordinate benefits between them – except when Medicare's secondary payer rules require Us to do otherwise. The process of determining benefits when multiple plans are involved is commonly referred to as coordination of benefits (COB).

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, we refer to your plan as "This Plan" and any other plan as "Plan." In the rest of the Benefit Booklet, Plan has the meaning listed in the "Definitions" section.

If you are covered under more than one Plan, benefits are calculated based on the rules listed below under "Order of Benefit Determination Rules." The rules specify whether the benefits of your Plan should be determined before or after those of another Plan.

The benefits of your Plan (i.e., This Plan):

1. Are not reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
2. May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in "Effect on the Benefits of This Plan" below.

When used in this section only, these terms have the following meanings:

Allowable Expense means a necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

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

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

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

Allowable Expense does not include the amount that is subject to the Primary high-deductible health plan's deductible, if we have 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.

Claim Determination Period means a Calendar Year. However, it does not include any part of a year during which you have no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

Plan means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous twenty-four (24) hour coverage. This includes prepayment, group practice, or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of

the United States Social Security Act as amended from time to time). It also does not include any Plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.

3. "No-fault" and group or group-type "fault" automobile insurance policies or contracts.

Each contract or other arrangement for coverage under 1. or 2. above is a separate Plan. If an arrangement has two parts and these rules apply only to one of the two, each of the parts is a separate Plan.

Primary Plan/Secondary Plan means the "Order Of Benefit Determination Rules" section states whether This Plan is a Primary Plan or Secondary Plan in relationship to another Plan covering you. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

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

When there are more than two Plans covering you, This Plan may be a Primary Plan in relationship to one or more other Plans and may be a Secondary Plan in relationship to a different Plan or Plans.

This Plan means the part of this Plan that provides benefits for health care expenses.

Order of Benefit Determination Rules

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

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

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

1. **Non-Dependent/Dependent**. The benefits of the Plan that covers you as an employee, Member or Subscriber (that is, other than as a Dependent) are determined before those of the Plan that covers you as a Dependent.
2. **Dependent Child/Parents Not Separated or Divorced**. Except as stated in rule 3 (below), when This Plan and another Plan cover the same child as a Dependent of different persons (called "parents"):

    a. The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
    b. If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

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

3. **Dependent Child/Separated or Divorced Parents**. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the Plan of the parent with custody of the child;

   b. Then, the Plan of the spouse of the parent with custody of the child; and

   c. Finally, the Plan of the parent not having custody of the child.

   Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses, or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the Dependent child shall be determined according to rule 2 (above).

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **Active/Inactive Employee**. The benefits of a Plan which covers you as an employee or as a Dependent of an employee who is neither laid off nor retired are determined before those of a Plan which covers you as a former employee or as a Dependent of a former employee. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. **Continuation Coverage**. The benefits of a Plan that covers you as an employee, Member or Subscriber, or as a Dependent of such a person, are determined before those of a Plan that covers you as a person on state or federal continuation. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. **Longer/Shorter Length of Coverage**. If none of the above rules determines the order of benefits, the benefits of the Plan which covered you, as a Member or Subscriber, for the longer period are determined before those of the Plan which covered you for the shorter time.

Effect on the Benefits of This Plan

This section applies when, in accordance with the order of benefit determination rules, This Plan is a Secondary Plan in relationship to one or more other Plans. In that event, the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to below as "the other Plans."

The benefits of This Plan will be reduced when the Allowable Expenses in a Claim Determination Period are less than the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this section; and

2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this section, whether or not claim is made.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

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

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts We need. We may obtain needed facts from, or give them to, any other organization or person. We need not tell or obtain your consent to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

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" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments This Plan made is more than This Plan should have paid under this section, This Plan may recover the excess from one or more of:

1. The persons This Plan has paid or for whom This Plan has paid;
2. Insurance companies; or
3. Other organizations.

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

Medicare

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.

Except when federal law requires the Plan to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.

Physical Examination

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

Workers' Compensation

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

Other Government Programs

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

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. 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, worker's 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 injuries. The following apply:

- The Plan has first priority for the full amount of benefits it has paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice them.
- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any party or entity to recover the benefits paid under the Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim still held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, other expenses or costs you incur. The Plan further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

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

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

Your Duties

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

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

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

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

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

Right of Recovery and Adjustment

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

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We 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. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue

recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount the Plan paid for the Covered Services.

Transfer of Benefits

Only you, the Subscriber, and your Dependents, as shown on Our records, are entitled to Plan benefits. These rights are forfeited if you or any of your Dependents:

1. Transfer those rights; or

2. Aid any person in fraudulently obtaining Plan benefits.

You and your Dependents must reimburse the Plan for any benefits the Plan has paid in this context.

Relationship of Parties (Employer-Member Plan)

Neither the Employer nor any Member is the agent or representative of Anthem Blue Cross and Blue Shield.

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

Important Note

The Employer, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Benefit Booklet and Administrative Services Agreement constitutes a contract solely between the Employer and Wisconsin Collaborative Insurance Company, dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Wisconsin. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Modifications

This Benefit Booklet allows the Employer to make the Plan coverage available to eligible Members. However, this Benefit Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Administrative Services Agreement, or by mutual agreement between the Employer and Us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice We provide to the Employer about the change. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Benefit Booklet.

Conformity with Law

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

Clerical Error

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

Policies and Procedures

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

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

Program Incentives

We, on behalf of the Employer, may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Medical Policy and Technology Assessment

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

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

Payment Innovation Programs

We pay 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 us 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 us 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 us or to us under the Program(s), and You do not share in any payments made by Network Providers to us under the Program(s).

Waiver

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

Plan's Sole Discretion

The Plan may cover services and supplies not specifically described in the Benefit Booklet if We determine such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The following provision only applies where the interpretation of the Plan is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We shall have all powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of the Plan and the interpretation of the Benefit Booklet. This includes, without limitation, the power to construe the Administrative Services Agreement to determine all questions arising under the Plan, to resolve Member 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. We have complete discretion to interpret the Benefit Booklet. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with the Plan's Maximum Allowable Amount. Our decision shall not be overturned unless determined to be arbitrary and capricious. However, a Member may utilize all applicable complaint and appeals procedures.

The Member may request an advance determination as to whether a treatment, service, or supply is a Covered Service by submitting a request in writing to Our Member Services Department. Where prior written approval is given, the Plan will pay benefits if, at the time the treatment, service or supply is provided the Member's coverage is in force and the Plan's approval has not expired.

If benefit levels change under this Plan, you are entitled to the level of benefits in effect on the date services or supplies were rendered.

14 DEFINITIONS

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

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

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

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

Administrator - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Administrator is Wisconsin Collaborative Insurance Company ("WCIC") and Blue Cross Blue Shield of Wisconsin dba Anthem Blue Cross and Blue Shield. *The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.*

Benefit Booklet - This summary of terms of your (health) benefits.

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

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

Biosimilar/Biosimilars - A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference

product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Brand Name Drug – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies after the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Copayment – A specific dollar amount of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. The Copayment does not apply to any Deductible that you are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or amount charged by the Provider.

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

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

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

The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission except as otherwise specified in "Benefits after Termination."

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

Covered Transplant Procedure - Any Medically Necessary human organ and bone marrow / stem cell transplant / transfusion as determined by Us including necessary acquisition procedures, collection and storage, and including Medically Necessary preparatory myeloblative therapy.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. Care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing
- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation

- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

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

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

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

Designated Pharmacy Provider - A Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with Anthem or a Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Effective Date – The date that a Subscriber's coverage begins under the Plan. You must be Actively At Work on your Effective Date for your coverage to begin. If you are not Actively At Work on your Effective Date, your Effective Date changes to the date that you do become Actively At Work.

A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise indicated in this Benefit Booklet.

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

Emergency (Emergency Medical Condition) - A medical or behavioral health condition that involves acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson with an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in:

1. Serious jeopardy to your health or the health of another person, or, for a pregnant women, serious jeopardy to the health of the woman or her unborn child;
2. Serious impairment to your bodily functions; or
3. Serious impairment of one or more of your body organs or parts.

It includes traumatic bodily injuries that result from an accident.

Emergency Care – A medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff

and facilities available at the Hospital, such further medical or behavioral health examinations and treatment as are required to Stabilize the patient.

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

Enrollment Date – The day the Employer or Member signs up for coverage or, when there is a waiting period, the first day of the waiting period (normally the date that employment begins).

Experimental / Investigative - Any procedures, treatment, supply, device, equipment, facility, or drug (all services), determined by Our Medical Director or his or her designee NOT to:

- Have final approval from the appropriate government regulatory body; or
- Have the scientific evidence which permits conclusions concerning the effect of the technology on health outcomes; or
- Improve the net health outcome; or
- Be as beneficial as any established alternative; or
- Show improvement outside the investigational settings.

In addition to the above criteria, We will consider the degree of acceptance of the product or service in the organized medical community.

A request for an advance determination may be submitted in writing to Our Member Services Department at the address listed in the front of this handbook. A decision will be made within five (5) working days of receiving the request. If prior written approval for a treatment, service or supply is provided, benefits will be paid if the Member's coverage is in force and if the approval has not expired at the time such treatment, service or supply is provided.

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

Fees - The periodic charges that are required to be paid by you and/or the Employer to maintain the benefits under the Plan.

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

Generic Drugs – Prescription Drugs that have been determined by the FDA to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency, and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

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

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a full day's room and board charge is made. This does not apply to a Member who is placed under observation for fewer than 24 hours.

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

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

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

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

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

Medically Necessary / Medical Necessity - Procedures, supplies, equipment, or services that We determine to be:

1. Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
2. Provided for the diagnosis or direct care and treatment of the medical condition; and
3. Within the standards of good medical practice within the organized medical community; and
4. Not primarily for the convenience of the patient's Physician or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely provided.

The most appropriate procedure, supply, equipment, or service must satisfy the following requirements:

1. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and
2. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
3. For Hospital stays, acute care as an Inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The most appropriate procedure, supply, equipment, or service must also be cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate.

Medicare - The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

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

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

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

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or, with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy network.

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

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

Non-Network Provider - A Provider who has not entered into a contractual agreement with Us for the Network associated with the Plan. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under the Plan are also considered Non-Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement nor otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug Services to you for the Specialty Pharmacy network.

Non-Network Transplant Provider - Any Provider that has **NOT** has been designated as a "center of excellence" by Us or has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

Non-Primary Procedure - A separate surgical procedure performed by a Physician on the same patient during the same operative session or on the same day.

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

Out of Pocket Limit - A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a Member and/or family, then no additional Deductibles, Coinsurance, and Copayments are required for that person and/or family unless otherwise specified in this Benefit Booklet and/or the Schedule of Benefits.

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

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

Pharmacy and Therapeutics (P&T) Process (Committee) – A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Physicians. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market

dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

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

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

1. Compounded (combination) medications, when all of the ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
2. Insulin, diabetic supplies, and syringes.

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

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

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

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

- **Alternative Care Facility** – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan allows, which provides Outpatient Services primarily for but not limited to:
    1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
    2. Surgery
    3. Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility** - A facility, with an organized staff of Physicians, that:
    1. Is licensed as such, where required;
    2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

4. Does not provide Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Cardiac Rehabilitation Specialist**
- **Certified Advance Registered Nurse Practitioner** - See information under "Nurse Practitioner" below.
- **Certified Nurse Midwife**
- **Certified Operating Room Technician** - When services are supervised and billed for by an employer M.D. for surgical assistance only.
- **Certified Registered Nurse Anesthetis**t - When services are performed in collaboration with an M.D. and billed by a certified facility or Hospital.
- **Certified Surgical Assistant** - See information under "Surgical Assistant" below.
- **Certified Surgical Technician** - When services are supervised and billed for by an employer M.D. for surgical assistance only.
- **Dialysis Facility** - A facility that mainly provides dialysis treatment, maintenance, or training to patients as an Outpatient or at your home. It is not a Hospital.
- **Facility** - A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, accredited, registered or approved by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by us.
- **Home Health Care Agency** - A facility, licensed in the state in which it is located, which:
    - Provides skilled nursing and other services on a visiting basis in the Member's home; and
    - Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.
- **Home Infusion Facility** - A facility which provides a combination of:

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

    in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.
- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care, which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.
- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

1. Provides room and board and nursing care for its patients;
2. Has a staff with one or more Physicians available at all times;
3. Provides 24 hour nursing service;
4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
5. Is fully accredited by The Joint Commission.

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

- **Laboratory (Clinical)**
- **Licensed Marriage & Family Therapist (L.M.F.T.)**
- **Licensed Practical Nurse** - When services are supervised and billed for by an employer M.D.
- **Licensed Professional Counselors**
- **Nurse Practitioner** - An individual licensed as a registered nurse, who:

  1. Is certified as a primary care Nurse Practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or
  2. Holds a master's degree in nursing from an accredited school of nursing; or
  3. Before March 31, 1990, successfully completed a formal one (1) year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care. The program must include at least four (4) months of classroom instruction and a component of supervised clinical practice, and award a degree, diploma or certificate to individuals who successfully complete the program; or
  4. Has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but does not satisfy the requirements set forth in paragraph (3) above, and has performed such an expanded role for a total of twelve (12) months during the eighteen (18) month period ending July 1, 1978.

- **Occupational Therapist**
- **Pharmacy (Pharmacist)** - An establishment licensed by state law to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist**
- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), doctor of dental medicine (D.D.M.), dental surgeon (D.D.S.), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).
- **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
- **Registered Nurse First Assistant** - When services are supervised and billed for by an employer M.D.
- **Registered Nurse**
- **Regulated Physician's Assistant**
- **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Residential Treatment Center / Facility** - A Provider licensed and operated as required by law, which includes:

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

  The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

  1. Nursing care
  2. Rest care
  3. Convalescent care
  4. Care of the aged
  5. Custodial Care
  6. Educational care

- **Respiratory Therapist (Certified)**

- **Retail Health Clinic** - A facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physician Assistants and Nurse Practitioners.
- **Skilled Nursing Facility** - - A Facility operated alone or with a Hospital that cares for you after a Hospital stay when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

  1. Mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. Provides care supervised by a Physician;
  3. Provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
  4. Is not a place primarily for care of the aged, Custodial or domiciliary care, or treatment of alcohol or drug dependency; and
  5. Is not a rest, educational, or custodial Provider or similar place.

- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.
- **Speech Therapist**
- **Supplier of Durable Medical Equipment, Prosthetic Appliances, and/or Orthotic Devices**
- **Surgical Assistant** - A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

  Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Transitional Care Provider** - Please refer to the "Behavioral Health & Substance Abuse Services" provision in the "Covered Services" section of this Benefit Booklet for further details.
- **Urgent Care Center** - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Provider Directory - A handbook (separate from this Benefit Booklet) that lists the Providers who participate in the Plan’s network. These are Providers who have a contract with Us to provide services under the Plan, often at discounted rates. Different Provider Directories exist for different plans. You can find the most current Provider Directory for the Plan by visiting Our website at www.anthem.com.

If you do not have Internet access, you can obtain a copy of the Provider Directory by calling Our Member Services department. We will supply this to you, free of charge.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how

you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Service Area – The geographical area where Covered Services are available.

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

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

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

Specialty Drug – Please refer to the "Prescription Drug Benefits" provision in the "Covered Services section for details.

Stabilize - The provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your condition is not likely to result from or during any of the following:

- Your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- Your transfer from an emergency department or other care setting to another facility; or
- Your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor – We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber - An employee or member of a group who is eligible to receive benefits under the Plan.

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

Totally Disabled (or Total Disability) - A condition resulting from illness or injury in which, as certified by a Physician:

1. You, the Subscriber, are not able to perform any occupation or business for which you are reasonably suited by your education, training, or experience. This also means that you are not, in fact, engaged in any occupation or business for wage or profit; and
2. The Dependent is unable to perform his or her normal activities of daily living.

Utilization Review - Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or facilities.

We, Us, Our - *Please refer to the definition of "Administrator" above.*

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Navajo
Bee ná ahóót'i' t'áá ni nizaad k'ehjí niká a'doowoł t'áá jiik'e. Naaltsoos bee atah nilínígíí bee néého'dólzingo nanitinígíí béésh bee hane'i bikáá' áaji' hodíílnih. Naaltsoos bee atah nilínígíí bee néého'dólzingo nanitinígíí béésh bee hane'i bikáá' áaji' hodíílnih. (TTY/TDD: 711)

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

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Group Name:	Muskego Norway School District
Group Identification Number:	00173646
Subgroup Identification Number:	0001

Mail to subscriber.

FWI13-MB MEME

Kerry G Tylenda
2256 S 74th Street
West Allis WI 53219

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