

MEDICAL BENEFIT BOOKLET

For

BALL STATE UNIVERSITY GROUP HEALTH PLAN



BALL STATE UNIVERSITY

Administered By



Si usted necesita ayuda en español para entender este documento, puede solicitarla gratuitamente llamando a Servicios al Cliente al número que se encuentra en su tarjeta de identificación.

If You need assistance in Spanish to understand this document, You may request it for free by calling Member Services at the number on Your Identification Card.

Effective 1-1-21

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

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

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

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

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

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

Verification of Benefits

Verification of benefits is available for Covered Persons or authorized healthcare Providers on behalf of Covered Persons. You may call Member Services with a benefits inquiry or verification of benefits during normal business hours (8:00 a.m. to 7:00 p.m. eastern time). **Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment.** CALL THE MEMBER SERVICES NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.

Identity Protection Services

If you are enrolled in an Anthem medical plan you automatically receive a basic level of Identity Repair Services and can voluntarily enroll in Credit and Identity Theft Monitoring Services, at no cost to you.

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COVERED PERSON RIGHTS AND RESPONSIBILITIES

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

You have the right to:

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

You have the responsibility to:

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

If You would like more information, have comments, or would like to contact the Claims Administrator, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on Your Identification Card.

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

How to Obtain Language Assistance

Anthem is committed to communicating with our Covered Persons about the Plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our 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.

NOTE: Words and phrases within this document that are denoted with initial capitalization have the meaning ascribed to them within the document itself, or within the Definitions section.

The company reserves the right to amend or terminate the plan at any time. You will be notified of any changes that affect Your benefits, as required by federal law.

Financial Tools

Each plan offers online financial tools to help You keep track of Your health care dollars. Plus You can track Your claims for Covered Services. You can review what You've spent on health care, view Your balance, or look up the status of a particular claim any time of the day.

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 an Out-of-Network Provider, You are responsible for any balance due between the Out-of-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Deductibles, and non-covered charges.

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

SCHEDULE OF BENEFITS FOR HSA Qualified Health Plan

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

Welcome to the HSA Qualified Health Plan!

The HSA Qualified Health Plan (HSA Plan) administered by the Claims Administrator is an innovative approach to health benefits for eligible Employees of Ball State University (the University).

With the HSA plan, You have health coverage available to You for which You and the University share the cost. This coverage has two components designed to work together to provide You flexibility and control in choosing the health care services You and Your family members receive and in choosing how the cost of these services is paid. Bottom line, the plans are designed to help You – and Your family – take control of Your health care dollars and decisions.

How the HSA Plan Works

The HSA plan is an innovative approach to health benefits that puts You in charge of the money You spend for health care services and helps You get the most out of Your employer-sponsored health coverage. With the HSA plan, You have flexibility and control in choosing the health care services You and Your family members receive – and in determining how the cost of these services is paid.

The HSA Plan – In Brief

First - **Use Your health savings account to pay for Covered Services:**

Health Savings Account

With the Health Savings Account (HSA), You can contribute pre-tax dollars to Your HSA. Others may also contribute dollars to Your account. You can use the dollars to help meet Your annual Deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

Plus – To help You stay healthy, use:

Preventive Care

100% coverage for nationally recommended services using Network Providers.

No deductions from the HSA or Out-of-Pocket costs for You as long as You receive Your preventive care from a Network Provider. If You choose to go to an Out-of-Network Provider, Your Deductible or Traditional Health Coverage benefits will apply.

If needed -

Traditional Health Coverage

Traditional Health Coverage is made available by the University on a self-funded basis and helps to protect You and Your family in case You have significant health care expenses. Coverage is effective once You have met an up-front Out-of-Pocket cost for covered expenses (Your Deductible). Once coverage is effective, the Plan will reimburse a percentage of the cost for Covered Services. You will be responsible for covering the remainder of the expense of Covered Services, up to an annual Out-of-Pocket Maximum. After this amount has been met, You will receive coverage for Covered Services for the remainder of the Plan year as specified elsewhere in this Benefit Booklet. The Traditional Health Coverage is governed by the details contained elsewhere in this document.

Contributions to Your Health Savings Account

For 2021, contributions can be made to Your HSA up to the following amount:

Contributions to Your HSA	
Individual Coverage	Maximum annual contribution: \$3,600 including the university seed amount of \$528
Family Coverage	Maximum annual contribution: \$7,200 including the university seed amount of \$1,320
HSA Catch-up Contributions	\$1,000 maximum in addition to the above contribution limit (age 55 or older)

Schedule of Benefits HSA Qualified Health Plan	Network	Out-of-Network
Calendar Year Deductible – Combined Limit Applies		
Individual	\$2,500	\$2,500*
Employee + Children	\$5,000	\$5,000*
Family	\$5,000	\$5,000*
<p>Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.</p> <p>All medical is subject to the Deductible and apply to the Out-of-Pocket Maximum except for Out-of-Network Human Organ and Tissue Transplant Coinsurance. The Family Deductible must be satisfied by either one Member or all Members collectively before any Covered Services are paid by the Plan except for services with no Coinsurance.</p> <p>*Amounts satisfied toward the Network calendar year Deductible will be applied toward the Out-of-Network calendar year Deductible and amounts satisfied toward the Out-of-Network calendar year Deductible will be applied toward the Network calendar year Deductible.</p>		
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)		
Plan Pays	80%	50%
Covered Person Pays	20%	50%
<p>All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.</p>		
Out-of-Pocket Maximum Per Calendar Year		
<p>(Includes Coinsurance and the calendar year Deductible. Does <u>NOT</u> include precertification penalties, charges in excess of the Maximum Allowed Amount, Non-Covered Services or Out-of-Network Human Organ and Tissue Transplant Services.</p> <p>Additional Protection: For Your protection, the total amount You spend Out-of-Pocket is limited. Once You spend that amount, the Plan pays 100% of the cost for Covered Services for the remainder of the Plan year.</p>		

Schedule of Benefits HSA Qualified Health Plan		Out-of-Network
	Network	
Individual (Employee only)	\$4,750	\$6,450
Individual on Employee + Child or Family	\$7,150	\$12,900
Employee + Child or Family	\$8,250	\$12,900
<p>Amounts satisfied toward the Network Out-of-Pocket Maximum will be applied toward the Out-of-Network Out-of-Pocket Maximum and amounts satisfied toward the Out-of-Network Out-of-Pocket Maximum will be applied toward the Network Out-of-Pocket Maximum.</p> <p>When a Covered Person satisfies the individual Out-of-Pocket Maximum, the Plan pays 100% of the cost for Covered Services for the remainder of the Plan year for that Covered Person (Employee only - \$4,750; Individual on Employee + Child or Family plan - \$7,150). When the employee + child or family Out-of-Pocket Maximum (\$8,250) is satisfied by Covered Persons, the Plan pays 100% of the cost for Covered Services for all Covered Persons for the remainder of the Plan year.</p>		
Allergy Care		
• Testing – Physician or specialist Physician	20%	50%
• Treatment – Physician Coinsurance	20%	50%
• Treatment – specialist Physician Coinsurance	20%	50%
• Serum and allergy shots – Physician or specialist Physician	20%	50%
Behavioral Health / Substance Abuse Care		
Hospital Inpatient Services	20%	50%
Outpatient Services	20%	50%
Physician Services (Home and Office Visits) Including Online Visits	20%	50%
<p>Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided to the same extent and degree as for the treatment of physical illness and in compliance with state and federal law.</p>		
Clinical Trials		
Please see Clinical Trials under Benefits section for further information.	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received

Schedule of Benefits HSA Qualified Health Plan	Network	Out-of-Network
Dental & Oral Surgery / TMJ Services		
<ul style="list-style-type: none"> Accidental Injury to Natural Teeth - Treatment must be completed within 12 months of the Injury Oral Surgery / TMJ - Subject to Medical Necessity – excludes appliances and orthodontic treatment 	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Diagnostic Physician's Services		
Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:		
<ul style="list-style-type: none"> Primary care Physician Specialist Physician Diagnostic X-ray – office Diagnostic Blood Work – LabCorp, Quest Diagnostics, American Health Network 	20% 20% 20% 100% <u>after Deductible is met</u>	50% 50% 50% N/A
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Emergency Room, Urgent Care, and Ambulance Services		
Emergency room for an Emergency Medical Condition	\$200 Copayment then 20% (Copayment waived if admitted)	(See note below)
Emergency room visit (per visit) Coinsurance	\$200 Copayment then 20% (Copayment waived if admitted)	Covered at the Network benefit level
Urgent Care clinic visit for an Emergency Medical Condition Clinic visit (per visit) Coinsurance	20%	(See note below)
All other services	20%	
Ambulance Services (when Medically Necessary) Land / Air	20%	(See note below)

Schedule of Benefits HSA Qualified Health Plan	Network	Out-of-Network
<p>Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.</p> <p>Additionally, claims for treatment received in an emergency room for a non-emergency ER visit will be denied by Anthem. Exceptions to this provision will include: members under the age of 14, ER visits directed by your doctor, ER visits between 8:00 p.m. Saturday and 8:00 a.m. on Monday, or when the closest urgent care facility is more than 15 miles from your home.</p>		
<p>Eye Care</p> <ul style="list-style-type: none"> Office visit – medical eye care exams (treatment of disease or Injury to the eye) <ul style="list-style-type: none"> ▶ Primary care Physician Coinsurance ▶ Specialist Physician Coinsurance Treatment other than office visit <p>Routine eye exams are not a Covered Service except for Preventive Care services for Children.</p>		
<p>Gene Therapy Services</p> <ul style="list-style-type: none"> Precertification required 	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
<p>Hearing Care</p> <ul style="list-style-type: none"> Office visit – Audiometric exam / hearing evaluation test <ul style="list-style-type: none"> ▶ Primary care Physician Coinsurance ▶ Specialist Physician Coinsurance <p>Routine hearing exams are not a Covered Service except for Preventive Care services for Children.</p>		
Home Health Care Services	20%	50%
<p>Hospice Care Services</p> <ul style="list-style-type: none"> Bereavement is covered Respite Care is covered 	20%	50%

Schedule of Benefits HSA Qualified Health Plan	Network	Out-of-Network
Hospital Inpatient Services – Precertification Required		
• Room and board (Semiprivate or ICU/CCU)	20%	50%
• Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient Physical Therapy, etc.)	20%	50%
• Pre-Admission testing	20%	50%
• Physician Services:		
▶ Surgeon	20%	50%
▶ Anesthesiologist	20%	50%
▶ Radiologist	20%	50%
▶ Pathologist	20%	50%
<p>*Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges.</p>		
Maternity Care & Other Reproductive Services		
• Physician's office:		
Global care (includes pre-and post-natal, delivery) –		
• Primary care Physician (includes obstetrician and gynecologist) Coinsurance	20%	50%
• Specialist Physician Coinsurance	20%	50%
• Midwife (Precertification required)	20%	50%
Physician Hospital / Birthing Center Services (Precertification required)		
• Physician's services	20%	50%
• Newborn nursery services (well baby care)	20%	50%
• Circumcision	20%	50%
• Note: Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be precertified.		

Schedule of Benefits HSA Qualified Health Plan	Network	Out-of-Network
Infertility Services <ul style="list-style-type: none"> Covered for services to diagnose infertility only, treatment of infertility is not covered. Treatment for underlying medical conditions are covered as medical. <p>Non-covered Services include but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.</p>	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received
Sterilization Services (Precertification required for Inpatient procedures) <p>Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section in Covered Services for further details.</p> <ul style="list-style-type: none"> Vasectomy 	20%	50%
Medical Supplies and Equipment <ul style="list-style-type: none"> Medical Supplies Durable Medical Equipment Orthotics Foot and Shoe Prosthetic Appliances (external) <ul style="list-style-type: none"> Including Cochlear Implants 	20%	20%
Nutritional Counseling for Diabetes	20%	50%
Outpatient Hospital / Facility Services <ul style="list-style-type: none"> Outpatient facility Lab and x-ray services Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.) 	20%	50%

Schedule of Benefits HSA Qualified Health Plan	Network	Out-of-Network
Physician Services (Home and Office Visits)		
• Primary care Physician	20%	50%
• Specialist Physician	20%	50%
• Ball State Employee Quick Clinic	100% <u>after Deductible is met</u>	N/A
Important Note on Office Visits at an Outpatient Facility: If You have an office visit with Your Primary Care Physician or Specialty Care Physician at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under the “Outpatient Facility” section earlier in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
Office Surgery	20%	50%
Online Visits (Other than Behavioral Health & Substance Abuse; see Behavioral Health/Substance Abuse Care section for further details)	20%	50%
Prescription Injectable Drugs / Prescription Drugs Dispensed in the Physician’s Office	20%	50%
Note: Specialty drugs should be sourced through CVS/Caremark Specialty Pharmacy		
Preventive Services	Covered at 100%	Covered at the Out-of-Network benefit level
Skilled Nursing Facility	20%	50%
Surgical Services	20%	50%
<ul style="list-style-type: none"> • Gastric Bypass / Obesity Surgery • Includes Bariatric Surgery (lapband, sleeve, or gastric bypass surgery only). Must have at least two years participation in medical plan. 	20%	50%

Schedule of Benefits HSA Qualified Health Plan	Network	Out-of-Network
Therapy Services (Outpatient)		
Primary care Physician –Coinsurance, per visit	20%	50%
Specialist Physician or other –Coinsurance per visit	20%	50%
<ul style="list-style-type: none"> • Physical Therapy – 60 day visit limitation • Occupational Therapy – 60 day visit limitation • Speech Therapy – 60 day visit limitation • Cardiac Rehabilitation – 36 day visit limitation 	20%	50%
• Chiropractic Care – 24 day visit limitation	20%	50%
• Radiation Therapy	20%	50%
• Chemotherapy	20%	50%
• Respiratory Therapy	20%	50%
• Vision Therapy	20%	50%
Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.		
Transgender Surgery	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received

Schedule of Benefits HSA Qualified Health Plan	Network	Out-of-Network
<p>Transplants</p> <p>Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy.</p> <p>The Center of Excellence requirements do not apply to cornea and kidney transplants; and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period.</p> <p>Note: Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Member Services, ask to be connected with the Transplant Case Manager for further information.)</p> <p>Transplant Benefit Period</p>	<p>Center of Excellence/Network Transplant Provider</p> <p>Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Member Services number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)</p>	<p>Out-of-Network Transplant Provider</p> <p>Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.</p>
<p>Covered Transplant Procedure during the Transplant Benefit Period</p> <ul style="list-style-type: none"> Care coordinated through a Network Transplant Provider/ Center of Excellence – not subject to Deductible When performed by an Out-of-Network Transplant Provider - subject to Deductible, does not apply to the Out of Pocket Maximum. You are responsible for any charges from the Out-of-Network Transplant Provider that exceed the Maximum Allowed Amount. 	<p>Non-BDCT Facility 20%</p> <p>BDCT Facility 100% covered after Deductible is met</p>	<p>Non-BDCT Facility Not Covered</p> <p>BDCT Facility 100% covered after Deductible is met</p>

Schedule of Benefits HSA Qualified Health Plan	Network	Out-of-Network
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient) <ul style="list-style-type: none"> Includes unrelated donor search up to \$30,000 per transplant. Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement) Eligible Travel and Lodging – Limited to \$150/day with maximum of \$2,500 for organ transplants Network and Out-of-Network subject to Claims Administrator's approval. All Other Covered Transplant Services 	<p>Non-BDCT Facility 20%</p> <p>BDCT Facility 100% covered after Deductible is met</p> <p>Covered, as approved, up to a \$17,500 benefit limit</p> <p>Non-BDCT Facility 20%</p> <p>BDCT Facility 100% covered after Deductible is met</p> <p>Benefits are paid based on the setting in which Covered Services are received</p>	<p>Non-BDCT Facility Not Covered</p> <p>BDCT Facility 100% covered after Deductible is met</p> <p>Covered, as approved, up to a \$17,500 benefit limit. You are responsible for 50% of search charges. These charges will NOT apply to the Out-of-Pocket Maximum.</p> <p>Non-BDCT Facility Not Covered</p> <p>BDCT Facility 100% covered after Deductible is met</p> <p>Benefits are paid based on the setting in which Covered Services are received</p>

SCHEDULE OF BENEFITS FOR HIGH DEDUCTIBLE WELLNESS PPO PLAN

Schedule of Benefits High Deductible Wellness PPO Plan	Network	Out-of-Network
Calendar Year Deductible – Combined Limit Applies		
Individual (Employee only)	\$1,300	\$2,600*
Employee + Children	\$3,900	\$7,800*
Family	\$3,900	\$7,800*
Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible.		
All Covered Services are subject to the Deductible unless otherwise specified in this booklet.		
*Amounts satisfied toward the Network calendar year Deductible will be applied toward the Out-of-Network calendar year Deductible and amounts satisfied toward the Out-of-Network calendar year Deductible will be applied toward the Network calendar year Deductible.		
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)	Network	Out-of-Network
Plan Pays	80%	50%
Covered Person Pays	20%	50%
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		
Out-of-Pocket Maximum Per Calendar Year		
Includes all Coinsurance, Copayments and the Deductible amounts You incur in a Benefit Period, except prescription drug benefits, precertification penalties, or charges in excess of the Maximum Allowed Amount or Non-Covered Services.		
Once the Out-of-Pocket Maximum is satisfied, no additional Coinsurance or Copayment will be required for the Covered Person for the remainder of the Benefit Period except for the services listed above.		
Individual (Employee only)	\$4,050	\$12,150
Employee + Children	\$9,750	\$29,250
Family	\$9,750	\$29,250

Schedule of Benefits High Deductible Wellness PPO Plan	Network	Out-of-Network
<p>Amounts satisfied toward the Network Out-of-Pocket Maximum will be applied toward the Out-of-Network Out-of-Pocket Maximum and amounts satisfied toward the Out-of-Network Out-of-Pocket Maximum will be applied toward the Network Out-of-Pocket Maximum.</p> <p>When a Covered Person satisfies the individual Out-of-Pocket Maximum, the Plan pays 100% of the cost for Covered Services for the remainder of the Plan year for that Covered Person, and when the employee + children or family Out-of-Pocket Maximum is satisfied by a Covered Person or Covered Persons, the Plan pays 100% of the cost for Covered Services for all Covered Persons for the remainder of the Plan year.</p>		
Allergy Care <ul style="list-style-type: none"> Testing – Physician or specialist Physician 20% 50% Treatment – Physician Coinsurance 20% 50% Treatment – specialist Physician Coinsurance 20% 50% Serum and allergy shots – Physician or specialist Physician 20% 50% 		
Behavioral Health / Substance Abuse Care <p>Hospital Inpatient Services 20% 50%</p> <p>Outpatient Services 20% 50%</p> <p>Physician Services (Home and Office Visits) 20% 50%</p> <p>Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided to the same extent and degree as for the treatment of physical illness and in compliance with state and federal law.</p>		
Clinical Trials <p>Please see Clinical Trials under Benefits section for further information.</p> <p>Benefits are paid based on the setting in which Covered Services are received</p> <p>Benefits are paid based on the setting in which Covered Services are received</p>		
Dental & Oral Surgery / TMJ Services <ul style="list-style-type: none"> Accidental Injury to Natural Teeth - Treatment must be completed within 12 months of the Injury Oral Surgery / TMJ - Subject to Medical Necessity – excludes appliances and orthodontic treatment <p>Benefits are paid based on the setting in which Covered Services are received</p> <p>Benefits are paid based on the setting in which Covered Services are received</p>		

Schedule of Benefits High Deductible Wellness PPO Plan	Network	Out-of-Network
Diagnostic Physician's Services		
Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:		
• Primary care Physician	20%	50%
• Specialist Physician	20%	50%
• Diagnostic X-ray – office	20%	50%
• Diagnostic Blood Work – LabCorp, Quest Diagnostics, American Health Network	Covered at 100%	N/A
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		
Emergency Room, Urgent Care, and Ambulance Services		
Emergency room for an Emergency Medical Condition	\$200 Copayment then 20% (Copayment waived if admitted)	(See note below)
Emergency room visit (per visit) Coinsurance	\$200 Copayment then 20% (Copayment waived if admitted)	Covered at the Network benefit level
Urgent Care clinic visit for an Emergency Medical Condition Clinic visit (per visit) Coinsurance	20%	(See note below)
All other services	20%	
Ambulance Services (when Medically Necessary) Land / Air	20%	(See note below)
Note: Care received Out-of-Network for an Emergency Medical Condition will be provided at the Network level of benefits if the following conditions apply: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; or (3) Serious dysfunction of any bodily organ or part. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.		
Additionally, claims for treatment received in an emergency room for a non-emergency ER visit will be denied by Anthem. Exceptions to this provision will include: members under the age of 14, ER visits directed by your doctor, ER visits between 8:00 p.m. Saturday and 8:00 a.m. on Monday, or when the closest urgent care facility is more than 15 miles from your home.		

Schedule of Benefits High Deductible Wellness PPO Plan	Network	Out-of-Network
Eye Care <ul style="list-style-type: none"> Office visit – medical eye care exams (treatment of disease or Injury to the eye) <ul style="list-style-type: none"> Primary care Physician Coinsurance Specialist Physician Coinsurance Treatment other than office visit <p>Routine eye exams are not a Covered Service except for Preventive Care services for Children.</p>	20% 20% 20%	50% 50% 50%
Gene Therapy Services <ul style="list-style-type: none"> Precertification required 	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Hearing Care <ul style="list-style-type: none"> Office visit – Audiometric exam / hearing evaluation test <ul style="list-style-type: none"> Primary care Physician Coinsurance Specialist Physician Coinsurance <p>Routine hearing exams are not a Covered Service except for Preventive Care services for Children.</p>	20% 20% 20%	50% 50% 50%
Home Health Care Services	20%	50%
Hospice Care Services <ul style="list-style-type: none"> Bereavement is covered Respite Care is covered 	20%	50%
Hospital Inpatient Services – Precertification Required <ul style="list-style-type: none"> Room and board (Semiprivate or ICU/CCU) Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient Physical Therapy, etc.) Pre-Admission testing 	20% 20% 20%	50% 50% 50%

Schedule of Benefits High Deductible Wellness PPO Plan	Network	Out-of-Network
<ul style="list-style-type: none"> Physician Services: <ul style="list-style-type: none"> ▶ Surgeon ▶ Anesthesiologist ▶ Radiologist ▶ Pathologist <p>*Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services. If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges.</p>	20% 20% 20% 20%	50% 50% 50% 50%
Maternity Care & Other Reproductive Services <ul style="list-style-type: none"> Physician's office: <p>Global care (includes pre-and post-natal, delivery) –</p> <ul style="list-style-type: none"> Primary care Physician (includes obstetrician and gynecologist) Coinsurance Specialist Physician Coinsurance Midwife (Precertification required) 	20% 20% 20%	50% 50% 50%
Physician Hospital / Birthing Center Services (Precertification required) <ul style="list-style-type: none"> Physician's services Newborn nursery services (well baby care) Circumcision Note: Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for a vaginal delivery or 96 hours for a cesarean section, must be pre-certified 	20% 20% 20%	50% 50% 50%
Infertility Services <ul style="list-style-type: none"> Covered for services to diagnose infertility only, treatment of infertility is not covered. Treatment for underlying medical conditions are covered as medical. <p>Non-covered Services include but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.</p>	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received

Schedule of Benefits High Deductible Wellness PPO Plan	Network	Out-of-Network
Sterilization Services (Precertification required for Inpatient procedures) Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section in Covered Services for further details.		
<ul style="list-style-type: none"> Vasectomy 	20%	50%
Medical Supplies and Equipment		
<ul style="list-style-type: none"> Medical Supplies 	20%	20%
<ul style="list-style-type: none"> Durable Medical Equipment 	20%	20%
<ul style="list-style-type: none"> Orthotics Foot and Shoe 	20%	50%
<ul style="list-style-type: none"> Prosthetic Appliances (external) <ul style="list-style-type: none"> Including Cochlear Implants 	20%	50%
Nutritional Counseling for Diabetes	20%	50%
Outpatient Hospital / Facility Services		
<ul style="list-style-type: none"> Outpatient facility 	20%	50%
<ul style="list-style-type: none"> Lab and x-ray services 	20%	50%
<ul style="list-style-type: none"> Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.) 	20%	50%
Physician Services (Home and Office Visits)		
<ul style="list-style-type: none"> Primary care Physician 	20%	50%
<ul style="list-style-type: none"> Specialist Physician 	20%	50%
<ul style="list-style-type: none"> Ball State Employee Quick Clinic 	Covered at 100%	N/A
Office Surgery	20%	50%
<ul style="list-style-type: none"> Including Anesthesia 	20%	50%

Schedule of Benefits High Deductible Wellness PPO Plan	Network	Out-of-Network
Online Visits	20%	50%
<ul style="list-style-type: none"> Consultations with your physician (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet) 	20%	50%
<ul style="list-style-type: none"> Consultations with your physician (PCP/Specialist) using audio only (telephone) 	20%	50%
Prescription Injectable Drugs / Prescription Drugs Dispensed in the Physician's Office Note: Specialty drugs should be sourced through CVS/Caremark Specialty Pharmacy	20%	50%
Important Note on Office Visits at an Outpatient Facility: If you have an office visit with your Primary Care Physician or Specialty Care Physician at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under the "Outpatient Facility" section earlier in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
Preventive Services	Covered at 100%	Covered at the Out-of-Network benefit level
Skilled Nursing Facility	20%	50%
Surgical Services	20%	50%
<ul style="list-style-type: none"> Gastric Bypass / Obesity Surgery Includes Bariatric Surgery (lapband, sleeve, or gastric bypass surgery only). Must have at least two years participation in medical plan. 	20%	50%
Therapy Services (Outpatient)		
Primary care Physician –Coinsurance, per visit	20%	50%
Specialist Physician or other –Coinsurance per visit	20%	50%
<ul style="list-style-type: none"> Physical Therapy – 60 day visit limitation Occupational Therapy – 60 day visit limitation Speech Therapy – 60 day visit limitation Cardiac Rehabilitation – 36 day visit limitation 	20%	50%
<ul style="list-style-type: none"> Chiropractic Care – 24 day visit limitation 	20%	50%

Schedule of Benefits High Deductible Wellness PPO Plan	Network	Out-of-Network
<ul style="list-style-type: none"> • Radiation Therapy • Chemotherapy • Respiratory Therapy • Vision Therapy <p>Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.</p>	20% 20% 20% 20%	50% 50% 50% 50%
Transgender Surgery	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received

Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Schedule of Benefits High Deductible Wellness PPO Plan	Network	Out-of-Network
Covered Transplant Procedure during the Transplant Benefit Period <ul style="list-style-type: none"> Care coordinated through a Network Transplant Provider/ Center of Excellence – not subject to Deductible When performed by Out-of-Network Transplant Provider (subject to Deductible, does not apply to the Out of Pocket Maximum). You are responsible for any charges from the Out-of-Network Transplant Provider that exceed the Maximum Allowed Amount. 	Non-BDCT Facility 20% BDCT Facility 100% covered	Non-BDCT Facility Not Covered BDCT Facility 100% covered
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient) <ul style="list-style-type: none"> Includes unrelated donor search up to \$30,000 per transplant. 	Non-BDCT Facility 20% BDCT Facility 100% covered	Non-BDCT Facility Not Covered BDCT Facility 100% covered
<ul style="list-style-type: none"> Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement) 	Covered, as approved, up to a \$17,500 benefit limit	Covered, as approved, up to a \$17,500 benefit limit. You are responsible for 50% of search charges. These charges will NOT apply to the Out-of-Pocket Maximum.
<ul style="list-style-type: none"> Eligible Travel and Lodging – Limited to \$150/day with maximum of \$2,500 for organ transplants Network and Out-of-Network subject to Claims Administrator's approval. 	Non-BDCT Facility 20% BDCT Facility 100% covered	Non-BDCT Facility Not Covered BDCT Facility 100% covered
<ul style="list-style-type: none"> All Other Covered Transplant Services 	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received

EMPLOYEE ELIGIBILITY AND ENROLLMENT

Covered Persons

To be eligible to enroll in the Plan as a Covered Person, an individual must be an Eligible Employee, or Dependent, and be entitled to participate in the Plan.

Dependents of Eligible Employees

If the Eligible Employee is covered by this Plan, he or she may enroll his or her eligible Dependents. A Dependent is eligible for coverage under the Plan on the *later of* the date that the Eligible Employee becomes a Covered Person *or* the date that the Eligible Employee acquires the Dependent, if on that date the Eligible Employee is a Covered Person.

Initial Enrollment

An Eligible Employee and/or his or her Dependents will become covered under the Plan on the date the Eligible Employee is hired or becomes an Eligible Employee if the Eligible Employee completes the enrollment process within 31 days of hire or eligibility. If You do not timely enroll in the Plan, You will be considered to have waived coverage and must wait until the next annual open enrollment period to enroll in coverage, unless You have a change in status or special enrollment right before the next annual open enrollment period.

Open Enrollment Period

If an Eligible Employee or his or her Dependents do not enroll when first eligible, they can enroll during the next open enrollment period for the Plan. If the enrollment process is completed timely, coverage will be effective the following January 1. If an Eligible Employee is not a Covered Person under the Plan and does not make an annual enrollment election, he or she will be considered to have waived coverage under the Plan.

Mid-Year Changes

Eligible Employees or Dependents who are affected by a change in status or other applicable event as described in the University's Flexible Benefit Plan and below, may make a mid-year election to change, drop or add coverage under the Plan. In order to make an election, the Eligible Employee must complete the enrollment process not more than 31 days after the change in status or applicable event (not more than 60 days in the case of special enrollment due to Medicaid). The election will be effective as of the date of the change or applicable event.

Effective Date of Coverage

Coverage will begin on the effective date of your employment or the date you became an Eligible Employee if You are Actively at Work. Coverage for Your Dependents will begin with the effective date of Your coverage. If You are not Actively at Work on the day coverage would otherwise begin under the Plan, You will be covered on the first day you are Actively at Work. If You are not Actively at Work due to a health status-related factor as defined in HIPAA, You will be treated as if you are Actively at Work for this purpose.

Working Spouse Rule

If an Eligible Employee's Spouse:

- is working full-time for an employer other than the University,
- is eligible through that employment for coverage under a group medical plan and the employer funds at least 60 percent of the coverage, and
- does not elect coverage for himself or herself under such group medical plan, the Spouse will not be eligible for coverage under this Plan. If Your Spouse elects coverage for himself or herself under such other group medical plan, he or she will be eligible for secondary coverage under this Plan as a Dependent.

In order to receive coverage under the Plan for a Spouse, the Eligible Employee must submit a completed Working Spouse Affidavit with Payroll & Employee Benefits.

Adding New Dependents

Any Dependent Child born while the Eligible Employee is eligible for coverage will be covered from birth but must be added to coverage within 31 days from the birth. Any Dependent Child adopted while the Eligible Employee is eligible for coverage will be covered from the date of placement for purposes of adoption providing the Eligible Employee adds the child to coverage within 31 days of the birth or adoption.

An Eligible Employee may add other new Dependents within 31 days of a marriage. Coverage will be retroactive to the date of eligibility.

If a Dependent is not timely added, the Eligible Employee will not be able to enroll the Dependent in coverage until the next annual open enrollment period or special enrollment period.

Qualified Medical Child Support Order

The Plan will provide benefits in accordance with the applicable requirements of a Qualified Medical Child Support Order, as defined by state or federal law, received by the Plan. If the Plan receives a medical child support order, the University will promptly notify the Eligible Employee, and each Child of the Eligible Employee identified in the order, of the procedures for determining whether the order is a Qualified Medical Child Support Order. Within a reasonable time after receipt of such order, the University will determine whether the order is a Qualified Medical Child Support Order and notify the Eligible Employee and each Child involved of the determination. If the order is a National Medical Support Notice, the University will determine whether the Notice is appropriately completed, complete Part A or Part B of the Notice, as applicable, and return said Part(s) to the issuing agency.

Special Enrollment

If (i) an Eligible Employee is a Covered Person, or (ii) an Eligible Employee is eligible for coverage under the Plan but has previously declined coverage for any reason, and if such Eligible Employee acquires a new Dependent through marriage, birth, adoption or placement for adoption, or becoming a stepchild, the following individuals may be enrolled as Covered Persons:

1. the Eligible Employee;
2. the new Dependent Child;
3. any existing Dependent Children; and/or
4. the new or any existing Spouse.

Provided, however, such enrollment will be effective only if the Eligible Employee has: (i) enrolled the dependent in coverage; (ii) certified the date the Dependent was acquired; (iii) agreed to make the required premiums; and (iv) made this election within 31 days after the date the new Dependent was acquired. In no event may an Eligible Employee enroll a Dependent under this subsection if the Eligible Employee is not already a Covered Person or the Eligible Employee is not contemporaneously enrolling himself or herself as a Covered Person. Coverage will be effective as of the date of the (i) birth, (ii) adoption or placement for adoption, (iii) stepchild becoming a Covered Person of the Eligible Employee's household, or (iv) the date of the marriage.

Loss of Other Coverage

An Eligible Employee who is otherwise eligible for coverage under this Plan may enroll as a Covered Person, and a Dependent of an Eligible Employee who is otherwise eligible for coverage under this Plan may be enrolled by the Eligible Employee as a Covered Person, if the following requirements are met:

1. the Eligible Employee previously declined coverage under this Plan for himself or herself and/or the Eligible Employee previously declined coverage under this Plan for his or her Dependents, because either he or she, or his or her Dependents, as applicable, had coverage under another group health plan or other health insurance;
2. the Eligible Employee and/or the Eligible Employee's Dependents actually had other health coverage at the time coverage under this Plan was declined; and
3. the other health coverage is lost due to "exhaustion of the COBRA continuation period," "loss of eligibility" under the other coverage, or cessation of employer contributions to the other coverage.

In order for the enrollment to be effective, the Eligible Employee must (i) contact the University and complete the enrollment process, if applicable; (ii) certify the date the other coverage was lost; (iii) agree to make the required premiums; and (iv) make this election within 31 days after the loss of other coverage due to "exhaustion of the COBRA continuation period," "loss of eligibility," or cessation of employer contributions. In no event may an Eligible Employee enroll a Dependent if the Eligible Employee is not already a Covered Person or the Eligible Employee is not contemporaneously enrolling himself or herself as a Covered Person. Coverage will be effective the first day after the loss of coverage, provided the election form is submitted to Payroll & Employee Benefits within 31 days after the loss of coverage.

For purposes of this subsection, "exhaustion of a COBRA continuation period" means that an individual's COBRA continuation period ceases for any reason other than either failure of the individual to pay premiums on a timely basis or for cause. For purposes of this subsection, "loss of eligibility" includes a loss of coverage as a result of legal separation, divorce, cessation of dependent status (due, for example, to reaching the maximum age for Child coverage), death, termination of employment (other than for cause), reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. "Loss of eligibility" also includes being a Covered Person of a class for which the Plan no longer offers coverage. "Loss of eligibility" does not occur if the individual failed to pay premiums on a timely basis or if coverage was terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

Special Enrollment for Medicaid and CHIP

An Eligible Employee who is otherwise eligible for coverage under the Plan may enroll as a Covered Person, and a Dependent of an Eligible Employee who is otherwise eligible for coverage under this Plan may be enrolled by the Eligible Employee as a Covered Person, if (i) the Eligible Employee or the Eligible Employee's Dependent, is covered under a Medicaid plan under Title XIX of the Social Security Act or a state children's health plan under Title XXI of the Social Security Act, and (ii) coverage under such plans is lost due to a loss of eligibility for such coverage. In addition, an Eligible Employee and/or an Eligible Employee's Dependent, may be enrolled under this Plan as a Covered Person if the Eligible Employee or Dependent becomes eligible for premium assistance, with respect to coverage under the Plan, under such Medicaid plan or state children's health plan (including any waiver or demonstration project conducted under or in relation to such plan).

In order for the enrollment in the preceding paragraph to be effective, the Eligible Employee must (i) complete the enrollment process within 60 days after the loss of other coverage or the date the Eligible Employee or Dependent is determined to be eligible for premium assistance; and (ii) have appropriate contributions made on behalf of the Eligible Employee or Dependent. In no event may an Eligible Employee enroll a Dependent if the Eligible Employee is not already a Covered Person or if the Eligible Employee is not contemporaneously enrolling himself or herself as a Covered Person. Coverage will be effective as of the date of the status change, provided that notification is provided to the University within 60 days.

Notice of Changes

Each Covered Person is required to notify the University of any "change in status" or other "applicable event" as set forth under this Section. If any change or revocation in coverage is desired due to a "change in status" or other "applicable event," as defined under the Flexible Benefits Plan, such change or revocation must be on account of the change in status or other applicable event and be necessary and appropriate as a result of the change in status or other applicable event, as described under the Flexible Benefits Plan. If a change in coverage is desired due to a change in status or other applicable event, notice must be given, and a new election or revocation of coverage must be completed not more 31 days after the change in status or other applicable event. The Flexible Benefits Plan election will be effective as of the date of the change in status, provided the appropriate election has been made.

In addition, Covered Persons should notify the University as soon as possible of: (i) a change in address; (ii) entrance into the military by the Covered Person; (iii) eligibility for and/or entitlement to Medicare; (iv) an individual ceasing to be a Dependent under the terms of the Plan; or (v) any other change in status or applicable event which might affect a Covered Person's coverage under the Plan. A Covered Person is responsible for notifying the University of any change in status or other applicable event, or the Covered Person may be liable for the costs, fees, and expenses incurred by the University for failure to notify. The University may request whatever documentation it deems necessary to substantiate a claimed change in status or other applicable event.

Dependent Eligibility Audits

The Plan reserves the right to conduct audits of Dependent eligibility at any time. Dependent coverage under the Plan will end if it is determined that the individual no longer meets the definition of a Dependent under the Plan. Coverage of the individual may be rescinded back to the date coverage began, or such other date as determined by the Claims Administrator, if it is determined that the Eligible Employee provided false information as to dependency status if done so fraudulently or as an intentional misrepresentation of fact.

HOW YOUR PLAN WORKS

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

Introduction

The Plan is a Preferred Provider Organization (PPO), which is a comprehensive plan. The Plan is divided into two sets of benefits: Network and Out-of-Network. If You choose a Network Provider, You will receive Network benefits. Utilizing this method means You will not have to pay as much money; Your Out-of-Pocket expenses will be higher when You use Out-of-Network Providers.

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

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

Network Services

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

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

To see a Doctor, call their office:

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

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

For services from Network Providers:

1. You will not need to file claims. Network Providers will file claims for Covered Services for You. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by Your Network Provider(s) for any Non-Covered Services You get or when You have not followed the terms of this Benefit Booklet.
2. Precertification will be done by the Network Provider. (See the **Health Care Management – Precertification** section for further details.)

Please read the **Claims Payment** section for additional information on Authorized Services.

After Hours Care

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

Out-of-Network Services

When You do not use a Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Benefit Booklet.

For services from an Out-of-Network Provider:

- the Out-of-Network Provider can charge You the difference between their bill and the Plan's Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments;
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);
- You will have to pay for services that are not Medically Necessary;
- You will have to pay for Non-Covered Services;
- You may have to file claims; and
- You must make sure any necessary Precertification is done. (Please see **Health Care Management – Precertification** for more details.)

How to Find a Provider in the Network

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

- See Your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and facilities that participate in this Plan's Network.
- Call 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, Anthem participates 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.

HEALTH CARE MANAGEMENT - PRECERTIFICATION

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

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

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

Acute Care at Home Programs

Anthem has programs available that offer acute care to Members where they live as an alternative to staying in a Facility, when the Member's condition and the Covered Services to be delivered, are appropriate for the home setting. We refer to these programs as Acute Care at Home Programs. These programs provide care for active, short-term treatment of a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. Acute care services are generally delivered by teams of health care Providers from a range of medical and surgical specialties. The Acute Care at Home Programs are separate from our Home Care Services benefit, are only available in certain Service Areas, and are only provided if the Member's home meets accessibility requirements.

Covered Services provided by Acute Care at Home Programs may include Physician services (either in-person or via telemedicine), diagnostic services, surgery, home care services, home infusion therapy, Prescription Drugs Administered by a Medical Provider, therapy services, and follow-up care in the community. Prescription Drugs at a Retail or Mail Order Pharmacy are not included in these Programs. Acute Care at Home Programs may also include services required to set up telemedicine technology for in-home patient monitoring, and may include coverage for meals.

Members who qualify for these programs will be contacted by our Provider, who will discuss how treatment will be structured, and what costs may be required for the services. Benefit limits that might otherwise apply to outpatient or home care services, (e.g., home care visits, physical therapy, etc.), may not apply to these programs.

Your participation in these programs is voluntary. If You choose to participate, Your Provider will discuss the length of time that benefits are available under the program (e.g., the Acute Care at Home Benefit Period) when You enroll. The Acute Care at Home Benefit Period typically begins on the date Your Acute Care at Home Provider sets up services in Your home, and lasts until the date You are discharged from the Program.

Any Covered Services received before or after the Acute Care at Home Benefit Period will be covered according to the other benefits of this Plan.

Coverage for or payment of the service or treatment reviewed is not guaranteed even if the Plan decides 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 Reviews:

- **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/Investigative as those terms are defined in this Benefit Booklet.

For admissions following Emergency Care, You, Your authorized representative or Doctor must tell the Claims Administrator no later than two business days after 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 Doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.

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

Failure to Obtain Precertification Penalty:

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

The following list is not all inclusive and is subject to change; please call the Member Services telephone number on Your Identification Card to confirm the most current list and requirements for the Plan.

Inpatient Admission:

- Acute Inpatient
- Acute Rehabilitation

- LTACH (Long Term Acute Care Hospital)
- Skilled Nursing Facility
- OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay)
- Emergency Admissions (Requires Plan notification no later than 2 business days after admission)

Diagnostic Testing:

- Cardiac Ion Channel Genetic Testing
- Chromosomal Microarray Analysis (CMA) for Developmental Delay, Autism Spectrum Disorder, Intellectual Disability (Intellectual Developmental Disorder) and Congenital Anomalies
- Gene Expression Profiling for Managing Breast Cancer Treatment
- Gene Mutation Testing for Solid Tumor Cancer Susceptibility and Management
- Genetic Testing for Breast and/or Ovarian Cancer Syndrome
- Preimplantation Genetic Diagnosis Testing
- Prostate Saturation Biopsy
- Wireless Capsule for the Evaluation of Suspected Gastric and Intestinal Motility Disorders

Durable Medical Equipment (DME)/Prosthetics:

- Augmentative and Alternative Communication (AAC) Devices/ Speech Generating Devices (SGD)
- Dynamic Low-Load Prolonged-Duration Stretch Devices
- Electrical Bone Growth Stimulation
- Functional Electrical Stimulation (FES); Threshold Electrical Stimulation (TES)
- Implantable Infusion Pumps
- Lower Limb Prosthesis and Microprocessor Controlled Lower Limb Prosthesis
- Oscillatory Devices for Airway Clearance including High Frequency Chest Compression and Intrapulmonary Percussive Ventilation (IPV)
- Prosthetics: Electronic or externally powered and select other prosthetics- (myoelectric-UE)
- Standing Frame
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Ultrasound Bone Growth Stimulation
- Wheeled Mobility Devices: Wheelchairs-Powered, Motorized, With or Without Power Seating Systems and Power Operated Vehicles (POVs)

Gender Reassignment Surgery

Human Organ and Bone Marrow/Stem Cell Transplants

- Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including Kidney only transplants)
- Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
 - Donor Leukocyte Infusion
 - Intrathecal treatment of Spinal Muscular Atrophy (SMA)
 - Stem Cell/Bone Marrow transplant (with or without myeloablative therapy)
 - (CAR) T-cell immunotherapy treatment
 - Axicabtagene ciloleucel (Yescarta™)
 - Tisagenlecleucel (Kymriah™)
- Gene Therapy Treatment & Replacement (Clear confirmation that the group has excluded the benefit is required. If the benefit is covered, pre-certification is required).

Mental Health/Substance Abuse (MHSA):

Pre-Certification Required

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)
- Residential Care
- Behavioral Health in-home Programs
- Applied Behavioral Analysis (ABA)**
- Intensive Outpatient Therapy (IOP) **
- Partial Hospitalization (PHP) **

Other Outpatient and Surgical Services:

- Air Ambulance (excludes 911 initiated emergency transport)
- Abdominoplasty ,Panniculectomy, Diastasis Recti Repair
- Ablative Techniques as a Treatment for Barrett's Esophagus
- Allogeneic, Xenographic, Synthetic and Composite Products for Wound Healing and Soft Tissue Grafting
- Hyperbaric Oxygen Therapy (Systemic/Topical)
- Autologous Cellular Immunotherapy for the Treatment of Prostate Cancer
- Axial Lumbar Interbody Fusion
- Balloon and Self-Expanding Absorptive Sinus Ostial Dilation
- Bariatric Surgery and Other Treatments for Clinically Severe Obesity
- Blepharoplasty
- Bone-Anchored and Bone Conduction Hearing Aids
- Brachioplasty
- Breast Procedures; including Reconstructive Surgery, Implants and other Breast Procedures
- Bronchial Thermoplasty for Treatment of Asthma
- Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Chin Implant, Mentoplasty, Osteoplasty Mandible
- Cochlear Implants and Auditory Brainstem Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System
- Corneal Collagen Cross-Linking
- Cryosurgical Ablation of Solid Tumors Outside the Liver
- Deep Brain, Cortical, and Cerebellar Stimulation
- Diaphragmatic/Phrenic Nerve Stimulation pacing systems
- Electric Tumor Treatment Field (TTF)
- Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities)
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Functional Endoscopic Sinus Surgery
- Immunoprophylaxis for respiratory syncytial virus (RSV)/ Synagis (palivizumab)
- Implantable Ambulatory Event Monitors and Mobile Cardiac Telemetry
- Implantable Middle Ear Hearing Aids
- Implantable or Wearable Cardioverter-Defibrillator

- Implanted (Epidural and Subcutaneous) Spinal Cord Stimulators (SCS)
- Implanted Devices for Spinal Stenosis
- Insertion/injection of prosthetic material collagen implants
- Percutaneous Vertebral Disc and Vertebral Endplate Procedures
- Intraocular Anterior Segment Aqueous Drainage Devices (without extraocular reservoir)
- Keratoprosthesis
- Liposuction/lipectomy
- Locoregional and Surgical Techniques for Treating Primary and Metastatic Liver Malignancies
- Lower Esophageal Sphincter Augmentation Devices for the Treatment of Gastroesophageal Reflux Disease (GERD)
- Lumbar Discography
- Lung Volume Reduction Surgery
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Manipulation Under Anesthesia of the Spine and Joints other than the Knee
- Mastectomy for Gynecomastia
- Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)
- Mechanical Embolectomy for Treatment of Acute Stroke
- Meniscal Allograft Transplantation of the Knee
- Occipital nerve stimulation
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Outpatient Cardiac Hemodynamic Monitoring Using a Wireless Sensor for Heart Failure Management
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Partial Left Ventriculectomy
- Penile Prosthesis Implantation
- Percutaneous and Endoscopic Spinal Surgery
- Percutaneous Neurolysis for Chronic Neck and Back Pain
- Percutaneous Vertebroplasty, Kyphoplasty and Sacroplasty
- Perirectal Spacers for Use During Prostate Radiotherapy (Space Oar)
- Photocoagulation of Macular Drusen
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing
- Procedures Performed on Male or Female Genitalia
- Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
- Procedures Performed on the Trunk and Groin
- Reduction Mammoplasty
- Repair of pectus excavatum/carinatum
- Sacral Nerve Stimulation (SNS) and Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary and Fecal Incontinence and Urinary Retention
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Skin-Related Procedures
- Subtalar Arthroereisis
- Surgical and Ablative Treatments for Chronic Headaches

- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Surgical Treatment of Obstructive Sleep Apnea and Snoring
- Therapeutic Apheresis
- Total Ankle Replacement
- Transanal Hemorrhoidal Dearterialization (THD)
- Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation (Radiofrequency and Cryoablation)
- Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
- Transcatheter Heart Valve Procedures
- Transcatheter Uterine Artery Embolization
- Transendoscopic Therapy for Gastroesophageal Reflux Disease and Dysphagia
- Transmyocardial/Periventricular Device Closure of Ventricular Septal Defects
- Treatment of Hyperhidrosis
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Treatment of Varicose Veins (Lower Extremities)
- Treatments for Urinary Incontinence
- Vagus Nerve Stimulation
- Venous Angioplasty with or without Stent Placement/ Venous Stenting
- Viscocanalostomy and Canaloplasty

Out of Network Referrals:

Out of Network Services for consideration of payment at in-network benefit level (may be authorized, based on network availability and/or medical necessity.)

Radiation Therapy/ Radiology Services

- Intensity Modulated Radiation Therapy (IMRT)
- MRI Guided High Intensity Focused Ultrasound Ablation for Non-Oncologic Indications
- Single Photon Emission Computed Tomography (SPECT) Scans for Noncardiovascular Indications
- Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for treating Primary or Metastatic Liver Tumors
- Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Malignant Lesions Outside the Liver- except CNS and Spinal Cord
- Wireless Capsule Endoscopy for Gastrointestinal Imaging and the Patency Capsule

Services not requiring pre-certification for coverage, but recommended for pre-determination of medical necessity due to the existence of post service claim edits and/or the potential cost of services to the member if denied by Anthem for lack of medical necessity:

- (1) Procedures, equipment, and/or specialty infusion drugs which have medically necessary criteria determined by Corporate Medical Policy or Adopted Clinical Guidelines.

Referrals:

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

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

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

Who is Responsible for Precertification?

Typically, Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, facility or attending Doctor ("requesting Provider") will get in touch with the Claims Administrator to ask for a Precertification. However, You may request a Precertification or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Network, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator's parent company.	Provider	<ul style="list-style-type: none"> The Provider must get Precertification when required
Out-of- Network/ Non-Participating	Member	<ul style="list-style-type: none"> Member must get Precertification when required. (Call Member Services.) Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary.

Blue Card Provider outside the service areas of the states listed in the column above and BlueCard Providers in other states not listed,	Member (Except for Inpatient Admissions)	<ul style="list-style-type: none"> Member must get Precertification when required. (Call Member Services.) Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. Blue Card Providers must obtain precertification for all Inpatient Admissions.
NOTE: For an Emergency Care admission, precertification is not required. However, You, Your authorized representative or Doctor must tell the Claims Administrator no later than 2 business days after admission or as soon as possible within a reasonable period of time.		

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

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card. If You are not satisfied with the Plan's decision under this section of Your benefits, please refer to the **Your Right To Appeal** section to see what rights may be available to You.

Decision and Notice Requirements

The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on federal laws. You may call the phone number on the back of Your Identification Card for more details.

Type of Review	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 Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Continued Stay/Concurrent 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 more information is needed to make a decision, the Claims Administrator will tell the requesting Provider of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required timeframe, the Claims Administrator will make a decision based upon the information it has.

The Claims Administrator will notify You and Your Provider of its decision as required by federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

From time to time certain medical management processes (including utilization management, case management, and disease management) may be waived, enhanced, changed or ended. An alternate benefit may be offered if in the Plan's sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

Certain qualifying Providers may be selected to take part in a program or a provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. Your claim may also be exempted from medical review if certain conditions apply.

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

You may find out whether a Provider is taking part in certain programs or a provider arrangement by contacting the Member Services number on the back of Your Identification Card.

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

Individual Case Management

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

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

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

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

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

COVERED SERVICES

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

Ambulance Service

Medically Necessary ambulance services are a Covered Service when:

- 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. This also includes services rendered by an Emergency Medical Services Provider Organization within their scope of practice, performed or provided as advanced life support services, and performed or provided during a response initiated through the 911 system regardless of whether the patient is transported. If multiple Emergency Medical Services Provider Organizations qualify and submit a claim to Us, We:
 - May reimburse for one (1) claim per patient encounter; and
 - Reimburse the claim submitted by the Emergency Medical Services Provider Organization that performed or provided the majority of advanced life support services to you.

And one or more of the following criteria are met:

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

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

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

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

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

Important Notes on Air Ambulance Benefits

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

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

Hospital to Hospital Transport

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

Assistant Surgery

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

Behavioral Health Care and Substance Abuse Treatment

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

Hospital Inpatient Care

Benefits for Inpatient Hospital and Physician charges are Covered Services.

Professional Outpatient Care

Covered Services include:

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

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

Breast Cancer Care

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

Breast Reconstructive Surgery

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

Cardiac Rehabilitation

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

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
 - a. The National Institutes of Health.
 - b. The Centers for Disease Control and Prevention.
 - c. The Agency for Health Care Research and Quality.
 - d. The Centers for Medicare & Medicaid Services.
 - e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary 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.

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

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

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

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

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

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

Routine patient costs in connection with an approved clinical trial include all items and services consistent with the coverage provided in the Plan that is typically covered for a Covered Person who is not enrolled in an approved clinical trial. Routine patient costs do not include: the investigational item, device or service itself; items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

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

Dental Services

Related to Accidental Injury

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

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

Other Dental Services

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

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

Diabetes

Equipment and Outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for Outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes. Screenings for gestational diabetes are covered under "Preventive Care."

Dialysis Treatment

The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Covered Person has not applied for eligible coverage available through Medicare.

Durable Medical Equipment

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

The equipment must meet the following criteria:

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

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Emergency Services

Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care including 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 Medical Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical or behavioral health examination and treatment as are required to Stabilize the patient. Emergency Service care does not require any Prior Authorization from the Plan.

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

The Maximum Allowed Amount for emergency care from an Out-of-Network Provider will be the greatest of the following:

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

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the **Schedule of Benefits**.

Gene Therapy Services

Your Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through Precertification. See **Health Care Management** - Precertification for details on the Precertification process. To be eligible for coverage, services must be Medically Necessary and performed by an approved Provider at an approved treatment center. Even if a Provider is a Network Provider for other services it may not be an approved Provider for certain gene therapy services. Please call us to find out which providers are approved Providers. (When calling Member Services, ask for the transplant case manager for further details.)

Services Not Eligible for Coverage

Your Plan does not include benefits for the following:

- a. Services determined to be Experimental/Investigational;
- b. Services provided by a non-approved Provider or at a non-approved Facility; or
- c. Services not approved in advance through Precertification.

General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

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

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

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

Habilitative Services

Benefits also include habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

Home Health Care Services

Home Health Care provides a program for the Covered Person's care and treatment in the home. Your coverage is outlined in the **Schedule of Benefits**. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Covered Person's attending Physician. Services may be performed by either Network or Out-of-Network Providers.

Some special conditions apply:

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

Covered Services:

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

Covered Services for Home Health Care do not include:

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

Hospice Care Services

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

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and 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 the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated caregiver and individuals with significant personal ties for one year after the Member's death.

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

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

Hospital Services

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

Network

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

Out-of-Network

Hospital Benefits

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

Hospital Visits

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

Human Organ and Tissue Transplant Services

Notification

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

Contact the Member Services telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Covered Person in maximizing their benefits by

providing coverage information including details regarding what is covered and whether any medical policies, Network requirements or Benefit Booklet exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Covered Person.

Covered Transplant Benefit Period

At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts 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. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

Prior Approval and Precertification

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

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

Transportation and Lodging

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

Licensed Speech Therapist Services

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

Maternity Care and Reproductive Health Services

Covered Services are provided for Network Maternity Care subject to the cost share stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the **Schedule of Benefits**.

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

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

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

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

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for further details.

Infertility Services

The Plan also includes benefits for the diagnosis of infertility. Covered Services include diagnostic and exploratory procedures to determine whether a Covered Person suffers from infertility. This includes surgical procedures to correct any diagnosed disease or conditions affecting the reproductive organs; however, this does not include in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization. See the **Schedule of Benefits** for benefit limitations and Coinsurance and Copayment amounts.

Sterilization Services

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

Medical Care

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

Nutritional Counseling

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

Obesity

Prescription Drugs and any other services or supplies for the treatment of obesity are not covered. Surgical treatment of obesity is only covered for patients meeting Medical Necessity criteria, as defined by the Plan.

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. See **Schedule of Benefits** for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. For Behavioral Health and Substance Abuse Online Visits, see the “Behavioral Health Care and Substance Abuse Treatment” section. 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 Physicians outside of the online care panel;
- benefit precertification; and
- Physician to Physician consultation.

Oral Surgery

Covered Services include only the following:

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

Although this Plan covers certain oral surgeries as listed above, many oral surgeries are not covered. Covered Services also include the following:

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

Other Covered Services

The Plan provides Covered Services when the following services are Medically Necessary:

- Chemotherapy and radioisotope, radiation and nuclear medicine therapy
- Diagnostic x-ray and laboratory procedures
- Dressings, splints, casts when provided by a Physician
- Oxygen, blood and components, and administration
- Pacemakers and electrodes
- Use of operating and treatment rooms and equipment

Out-of-Network Freestanding Ambulatory Facility

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

Out-of-Network Hospital Benefits

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

Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

Outpatient Surgery

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

Pediatric Neuropsychiatric Disorders

This Plan provides coverage for treatment of Pediatric Neuropsychiatric Disorders for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS); and pediatric acute-onset neuropsychiatric syndrome (PANS) including treatment with intravenous immunoglobulin therapy. Coverage will not be subject to dollar limits, Deductibles, Copayment or Coinsurance that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to other coverage under your Plan.

Physical Therapy, Occupational Therapy, Manipulation Therapy

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

Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements. Consultations between your Primary Care Physician and a Specialty Care Physician are included, when approved by Anthem.

Preventive Care

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

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

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force.
Examples of these services are screenings for:
 - a. Breast cancer;
 - b. Cervical cancer;
 - c. Colorectal cancer;
 - d. High Blood Pressure;
 - e. Type 2 Diabetes Mellitus;
 - f. Cholesterol;
 - g. Child and Adult Obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
 - a. Women's contraceptives, sterilization procedures, and counseling. Coverage includes contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants.
 - b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
 - c. Gestational diabetes screening.
5. Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
 - a. counseling;
 - b. Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

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

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

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

You may call Member Services using the number on Your ID card for additional information about these services. (or view the federal government's web sites, <http://www.healthcare.gov/center/regulations/prevention.html>; or <http://www.ahrq.gov/clinic/uspstfix.htm>; <http://www.cdc.gov/vaccines/>.)

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

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

- Artificial limbs and accessories. Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below.
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes);

Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act. This includes coverage for custom fabricated breast prostheses and one (1) additional breast prosthesis per breast affected by the mastectomy.

Reconstructive Surgery

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

Reconstructive surgery is covered only to the extent Medically Necessary:

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

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

Retail Health Clinic

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

Skilled Nursing Facility Care

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

Skilled Convalescent Care during a period of recovery is characterized by:

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Covered Person's residence.

Covered Services include:

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

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

Benefits will not be provided when:

- A Covered Person reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- No specific medical conditions exist that require care in a Skilled Nursing Facility;
- The care rendered is for other than Skilled Convalescent Care.

Surgical Care

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

Treatment of Accidental Injury in a Physician's Office

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

LIMITATIONS AND EXCLUSIONS

1. **Admissions for Non-Inpatient Services** - Admission or continued Hospital or Skilled Nursing Facility stay for medical care or diagnostic studies not medically required on an Inpatient basis.
2. **Administrative Charges** - Charges for any of the following:
 - a. Failure to keep a scheduled visit;
 - b. Completion of claim forms or medical records or reports unless otherwise required by law;
 - c. For Physician or Hospital's stand-by services;
 - d. For holiday or overtime rates.
 - e. Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
 - f. Specific medical reports including those not directly related to the treatment of the Covered Person, e.g., employment or insurance physicals, and reports prepared in connection with litigation.
3. **Allergy Services** - Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
4. **Alternative Therapies** - Hypnotherapy, acupuncture and acupuncture therapy. Services or supplies related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy at a salon, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST) and iridology-study of the iris. This exclusion also applies to, recreational or educational sleep therapy or other forms of self-care or non-medical self-help training and any related diagnostic testing.
5. **Before Coverage Begins / After Coverage Ends** - Services rendered or supplies provided before coverage begins or after coverage ends for a Covered Person.
6. **Biomicroscopy** - Biomicroscopy, field charting or aniseikonic investigation.
7. **Comfort and Convenience Items** - Personal comfort items such as those that are furnished primarily for Your personal comfort or convenience, including those services and supplies not directly related to medical care, such as guest's meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.
8. **Complications of/or Services Related to Non-Covered Services** - Services, supplies, or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the Non-Covered Service and would not have taken place without the Non-Covered Service.

Cosmetic Services - Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how You look or are given social reasons. No benefits are available for surgery or treatments to change the texture or look of Your skin or to change the size, shape or look of facial or body features (such as Your nose, eyes, ears, cheeks, chin, chest or breasts). This Exclusion does not apply to reconstructive surgery for breast symmetry after a mastectomy and surgery to correct birth defects and birth abnormalities.

Court-Ordered Services - Court-ordered services, or those required by court order as a condition of parole or probation unless Medically Necessary and approved by the Plan.
9. **Crime and Incarceration** - Injuries received while committing a crime as well as care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation. This Exclusion does not apply if you were the victim of a crime, including domestic violence.

10. **Custodial Care and Rest Care** - Custodial care, domiciliary care, rest cures, or travel expenses even if recommended for health reasons by a Physician. Inpatient room and board charges in connection with a Hospital or Skilled Nursing Facility stay primarily for environmental change, Physical Therapy or treatment of chronic pain.
11. **Daily Room Charges** - Daily room charges while the Plan is paying for an Intensive care, cardiac care, or other special care unit.
12. **Dental Care** - Dental care and treatment and oral surgery (by Physicians or dentists) including dental surgery; dental appliances; dental prostheses such as crowns, bridges, or dentures; implants; orthodontic care; operative restoration of teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery; vestibuloplasties; alveoplasties; dental procedures involving teeth and their bone or tissue supporting structures; frenulectomy. Any treatment of teeth, gums or tooth related service except otherwise specified as covered in this Benefit Booklet.
13. **Educational Services** - Educational services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunctions, learning disorders, behavioral training, and cognitive rehabilitation. This includes educational services, treatment or testing and training related to behavioral (conduct) problems, including but not limited to services for conditions related to autistic disease of childhood (except to the same extent that the Plan provides for neurological disorders and applied behavioral analysis), hyperkinetic syndromes, including attention deficit disorder and attention deficit hyperactivity disorder, learning impairments, behavioral problems, and mental and intellectual impairment. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
14. **Excessive Expenses** - Expenses in excess of the Plan's Maximum Allowed Amount.
15. **Employer or Association Medical / Dental Department** - Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
16. **Experimental / Investigative Services** - Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are, in the Claims Administrator's judgment, Experimental or Investigative for the diagnosis for which the Covered Person is being treated. An Experimental or Investigative service is not made eligible for coverage by the fact that other treatment is considered by a Covered Person's Physician to be ineffective or not as effective as the service or that the service is prescribed as the most likely to prolong life.
17. **Family Members** - Services rendered by a Provider who is a close relative or member of Your household. Close relative means wife or husband, parent or grandparent, child, brother or sister, by blood, marriage (including in-laws) or adoption.
18. **Foot Care** - Foot care only to improve comfort or appearance, routine care of corns, bunions (except capsular or related surgery), calluses, toe nails (except surgical removal or care rendered as treatment of the diabetic foot or ingrown toenail), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Covered Persons with impaired circulation to the lower extremities.
19. **Free Services** - Services and supplies for which You have no legal obligation to pay, or for which no charge has been made or would be made if You had no health insurance coverage.
20. **Government Programs** - Treatment where payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Covered Person had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.
21. **Health Spa** - Expenses incurred at a health spa or similar facility.

22. **Hearing Aids** - Hearing aids, hearing devices or examinations for prescribing or fitting them including bone-anchored hearing aids, unless listed as covered in this Benefit Booklet. This Exclusion does not apply to cochlear implants.
23. **Ineligible Hospital** - Any services rendered or supplies provided while You are confined in an Ineligible Hospital.
24. **Ineligible Provider** - Any services rendered or supplies provided while You are a patient or receive services at or from an Ineligible Provider.
25. **Infertility Services** - For artificial insemination; fertilization (such as in vitro or GIFT) or procedures and testing related to fertilization; infertility drugs and related services following the diagnosis of infertility.
26. **Inpatient Rehabilitation Programs** - Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Covered Person is medically stable and does not require skilled nursing care or the constant availability of a Physician or:
- a. the treatment is for maintenance therapy; or
 - b. the Covered Person has no restorative potential; or
 - c. the treatment is for congenital learning or neurological disability/disorder; or
 - d. the treatment is for communication training, educational training or vocational training.
27. **Maintenance Care** - Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, Injury or condition which is resolved or stable.
28. **Marital Counseling** - Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
29. **Medicare Benefits** - Services paid under Medicare or which would have been paid if the Covered Person had applied for Medicare and claimed Medicare benefits. With respect to end-stage renal disease (ESRD), Medicare shall be treated as the primary payer whether or not the Covered Person has enrolled Medicare Part B. For services provided pursuant to a private contract between the Covered Person and a Provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act. If You do not enroll in Medicare Part B when You are eligible, You may have large Out-of-Pocket costs. Please refer to Medicare.gov for more details on when You should enroll and when You are allowed to delay enrollment without penalties.
30. **Never Events** – The Plan will not pay for errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, which indicate a problem exists in the safety and credibility of a health care facility. The Provider will be expected to absorb such costs. This Exclusion includes, but is not limited to, such errors as operating on the wrong side of the body, operating on the wrong part of the body, using the wrong procedure, or operating on the wrong patient.
31. **Non-Approved Facility** - Services from a Provider that does not meet the definition of Facility.
32. **Non-Covered Services** - Any item, service, supply or care not specifically listed as a Covered Service in this Benefit Booklet.
33. **Not Medically Necessary Services**- Care, supplies, or equipment not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
34. **Obesity Services** - Any services or supplies for the treatment of obesity, including but not limited to, weight reduction, medical care or Prescription drugs, or dietary control (except as related to covered nutritional counseling). Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to Enteral feeding except when it's the sole means of nutrition. Food supplements. Services for Inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education. Any services or supplies that involve weight reduction as the main method of treatment, including medical, psychiatric

care, or counseling. Weight loss programs included but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. This exclusion does not apply to morbid obesity surgery when approved by the Plan.

35. **Over the Counter Drug Equivalents** - Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply may not be covered even written as a Prescription. This Exclusion does not apply to over-the-counter products that the Plan must cover as a "Preventive Care" benefit under Federal law with a Prescription.
36. **Prescription Drugs** - Any Prescription Drugs purchased at a retail or Home Delivery (Mail Service) Pharmacy. Drug coverage is provided by CVS/Caremark.
37. **Prescription Drugs Contrary to Approved Medical and Professional Standards** - Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
38. **Prescription Drugs Over Quantity or Age Limits** - Drugs which are over any quantity or age limits set by the Plan
39. **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** - Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by the Plan.
40. **Private Duty Nursing** – For Private Duty Nursing services except when provided through the "Home Care" benefit.
41. **Private Rooms** - Private room, except as specified as Covered Services.
42. **Research Screenings** – For examinations related to research screenings, unless required by law.
43. **Reversal of Sterilization** - Services related to or performed in conjunction with reverse sterilization.
44. **Routine Examinations** - Routine physical examinations, screening procedures, and immunizations necessitated by employment, foreign travel or participation in school athletic programs, recreational camps or retreats or any insurance program which are not called for by known symptoms illness or Injury except those which may be specifically listed as covered in this Benefit Booklet.
45. **Safe Surroundings** - Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or Injury.
46. **Sclerotherapy** - Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
47. **Services Not Specified as Covered** - No Benefits are available for services that are not specifically described as Covered Services in this Benefit Booklet. This exclusion applies even if Your Physician orders the service.
48. **Sexual Dysfunction** - Medical/ surgical services or supplies for treatment of male or female sexual or erectile dysfunctions or inadequacies, including treatment for impotency (except male organic erectile dysfunction) regardless of origin or cause. This exclusion also includes penile prostheses or Implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
49. **Shoes and Orthotics** - Shoe inserts, orthotics (except when prescribed by a physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
50. **Spider Veins** - Treatment of telangiectatic dermal veins (spider veins) by any method.
51. **Supplies or Equipment (Including Durable Medical Equipment) Not Medically Necessary** - Supplies or equipment not Medically Necessary for the treatment of an Injury or illness. Non-covered supplies are inclusive of but not limited to:
 - a. Band-aids, tape, non-sterile gloves, thermometers, heating pads, hot water bottles, home enema equipment, sterile water and bed boards;

- b. Household supplies, including but not limited to, deluxe equipment, such as motor-driven chairs or bed, electric stair chairs or elevator chairs;
 - c. The purchase or rental of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment;
 - d. Water purifiers, hypo-allergenic pillows, mattresses, or waterbeds, whirlpool, spa or swimming pools, air purifiers, humidifiers, dehumidifiers;
 - e. Escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances improvements made to a Covered Person's house or place of business and adjustments made to vehicles;
 - f. Air conditioners, humidifiers, dehumidifiers, or purifiers;
 - g. Rental or purchase of equipment if You are in a facility which provides such equipment;
 - h. Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications; and,
 - i. Other items of equipment that the Claims Administrator determines do not meet the listed criteria.
52. **Therapy Services** - Services for Outpatient therapy or rehabilitation other than those specifically listed as covered in this Benefit Booklet. Excluded forms of therapy include, but are not limited to, vestibular rehabilitation, primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, cognitive therapy, electromagnetic therapy, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or which are performed as a treatment for acne.
53. **Transplant Services** - The following services and supplies rendered in connection with organ/tissue/bone marrow transplants:
- a. Surgical or medical care related to animal organ transplants, animal tissue transplants, (except for porcine heart valves) artificial organ transplants or mechanical organ transplants;
 - b. Transportation, travel or lodging expenses for non-donor family members;
 - c. Donation related services or supplies, including search, associated with organ acquisition and procurement;
 - d. Chemotherapy with autologous, allogenic or syngenic hematopoietic stem cells transplant for treatment of any type of cancer not specifically named as covered; any transplant not specifically listed as covered.
54. **Transportation** - Transportation provided by other than a state licensed professional ambulance service, and Ambulance Services that are not Medically Necessary. Transportation to another area for medical care is also excluded except as stated as covered under the "Ambulance Service" section. Ambulance transportation from the Hospital to the home is not covered.
55. **Travel Costs and Mileage** - For mileage costs or other travel expenses, except as authorized by the Claims Administrator, on behalf of the University.
56. **Thermograms** - Thermograms and thermography.
57. **Vision Care** - Vision care services and supplies, including but not limited to eyeglasses, contact lenses, and related examinations and services. Analysis of vision or the testing of its acuity except as otherwise indicated in this Benefit Booklet. Service or devices to correct vision or for advice on such service. Orthoptic training is covered. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery, or for soft contact lenses due to a medical condition, i.e. diabetes.
58. **Vision Surgeries** - Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive problem.

59. **Waived Cost-Shares Out-of-Network** - For any service for which You are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
60. **Waived Fees** - Any portion of a provider's fee or charge which is ordinarily due from a Covered Person but which has been waived. If a provider routinely waives (does not require the Covered Person to pay) a Deductible or Out-of-Pocket amount, the Claims Administrator will calculate the actual Provider fee or charge the fee or charge by the amount waived.
61. **War / Military Duty** - Any disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related military service provided or available from the Veterans' Administration or military facilities except as required by law.
62. **Workers' Compensation** - Care for any condition or Injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law. If Workers' Compensation Act benefits are not available to You, then this Exclusion does not apply. This exclusion applies if You receive the benefits in whole or in part. This exclusion also applies whether or not You claim the benefits or compensation. It also applies whether or not You recover from any third party.

CLAIMS PAYMENT

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

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

How to File Claims

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

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

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

For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from the University or the Claims Administrator. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

Maximum Allowed Amount

General

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

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

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

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

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

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

Provider Network Status

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

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

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

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

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

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third party vendor that has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but contracted for other products with the Claims Administrator are also considered Out-of-Network. For the Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above.

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

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

Member Services is also available to assist You in determining the Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out of Pocket responsibility. Although 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.

Covered Person Cost Share

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

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

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

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

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

Authorized Services

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

Services Performed During Same Session

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

Processing Your Claim

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

Timeliness of Filing for Covered Person Submitted Claims

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

Necessary Information

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

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

Notice of Claim & Proof of Loss

After You get Covered Services, we must receive written notice of Your claim within 90 days in order for benefits to be paid. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and it must be sent to us within the time listed below or no benefits will be covered, unless otherwise required by law (e.g., Federal law allows exceptions for claims filed by the Veteran's Administration up to a maximum 6 years from the date of service).

Explanation of Benefits

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

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

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If You fail to cooperate (Including if You fail to enroll under Part B of the Medicare program where Medicare is the responsible payer), You will be responsible for any charge for services.

Inter-Plan Arrangements

Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard[®] Program

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

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

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

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

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

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

E. Nonparticipating Providers Outside the Claims Administrator’s Service Area

1. Allowed Amounts and Member Liability Calculation

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

2. Exceptions

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

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

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

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

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

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

• How Claims are Paid with Blue Cross Blue Shield Global Core

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

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

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

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

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

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

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

Unauthorized Use of Identification Card

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

Assignment

You authorize the Claims Administrator, in its own discretion and on behalf of the Employer, to make payments directly to Providers for Covered Services. In no event, however, shall the Plan's right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. The Claims Administrator also reserves the right, in its own discretion, to make payments directly to You as opposed to any Provider for Covered Service. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" 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 Claims Administrator (whether to any Provider for Covered Service or You) will discharge the Employer's obligation to pay for Covered Services. You cannot assign Your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA, if subject to ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

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

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

Questions About Coverage or Claims

If You have questions about Your coverage, contact the Plan Administrator or the Claims Administrator's Member Services Department. Be sure to always give Your member Identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- provider name and address (Hospital or Physician).

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

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

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

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

YOUR RIGHT TO APPEAL

Internal Claim Appeals

Initial Review of Claims

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

Initial Denial of Claims

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

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

Appeal of Claim Denial

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

Denial of Appeal

1. The claimant will receive notice of the Claims Administrator's decision on appeal within the time periods set forth in the chart at the end of this Section. If the claim is denied on appeal, the notice will serve as the Final Denial.
2. The Claims Administrator will provide the following information to the claimant free of charge as soon as possible and sufficiently in advance of the date on which the notice of Final Denial is required, such that the claimant has a reasonable opportunity to respond prior to that date: (i) any new or additional evidence considered, relied upon, or generated by the Claims Administrator (or at the direction of the Claims Administrator) in connection with the claim; and (ii) any new or additional rationale that forms the basis of the Claims Administrator's Final Denial, if any.
3. If the claim is denied on appeal, the claimant will be given notice which will contain a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim, as well as items (1), (2), (5), (6), (7), (8), and (9) under the "Initial Denial of Claims" section above, as well as: (i) a description of the review procedures and time limits, including information regarding how to initiate an appeal and information on the External Review process; and (ii) if the Denial is a Final Denial, a discussion of the decision. A decision on review will be final, conclusive, and binding on all persons.
4. If, after the Plan's denial, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.

Ongoing Treatments

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

Authorized Representative

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

Calculating Time Periods

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

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

Full and Fair Review

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

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

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

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

Exhaustion of Remedies

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

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

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

External Review Process

Application and Scope of External Review Process

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

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

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

Standard External Review Process for Claims

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

2. *Preliminary Review.* The Claims Administrator shall complete a preliminary review of the request for External Review within 5 business days to determine whether: (i) the claimant is or was covered under the Plan at the time the Covered Medical Service was requested or provided, as applicable; (ii) the type of claim is eligible for External Review; (iii) the claimant has exhausted (or is deemed to have exhausted) the Plan's internal claims and appeals process under the Plan; and (iv) the claimant has provided all the information and forms required to process an External Review. The Claims Administrator will issue a notification to the claimant within one business day of completing the preliminary review. If the request is complete, but ineligible for External Review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete, and the claimant shall be allowed to perfect the request for External Review by the later of the 4-month filing period described in paragraph (1) above, or within the 48-hour period following the receipt of the notification.
3. *Referral to Independent Review Organization (IRO).* The Claims Administrator will assign an IRO to the claimant's request for External Review. Upon assignment, the IRO will undertake the following tasks with respect to the claimant's request for External Review:
 - (a) Timely notify the claimant in writing of the request's eligibility and acceptance for External Review. This notice will include a statement that the claimant may submit in writing to the IRO, within 10 business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the External Review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
 - (b) Review all documents and any information considered in making a Final Denial received by the Claims Administrator. The Claims Administrator shall provide the IRO with such documents and information within five business days after the date of assignment of the IRO. Failure by the Claims Administrator to timely provide the documents and information will not delay the conduct of the External Review. If the Claims Administrator fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Final Denial. In such case, the IRO will notify the claimant and the Claims Administrator of its decision within one business day.
 - (c) Forward any information submitted by the claimant to the Claims Administrator within 1 business day of receipt. Upon receipt of any such information, the Claims Administrator may reconsider its Final Denial that is the subject of the External Review. Reconsideration by the Claims Administrator must not delay the External Review. The External Review may be terminated as a result of reconsideration only if the Claims Administrator decides to reverse its Final Denial and provide coverage or Payment. In such case, the Claims Administrator must provide written notice of its decision to the claimant and IRO within one business day, and the IRO shall then terminate the External Review.
 - (d) Review all information and documents timely received under a de novo standard. The IRO will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the information and documents provided, the IRO, to the extent the information and documents are available and the IRO considers them appropriate, will further consider the following in reaching a decision: (i) the claimant's medical records; (ii) the attending Health Care Professional's recommendation; (iii) reports from appropriate Health Care Professionals and other documents submitted by the Claims Administrator, the claimant, or the claimant's Physician; (iv) the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law; (v) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (vi) any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and (vii) the opinion of the IRO's clinical reviewer(s) after considering the information described in

this paragraph to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

4. *Notice of Final External Review Decision.* The IRO will provide written notice of Final External Review Decision within 45 days after the IRO receives the request for External Review. Such notice will be delivered to the claimant and the Claims Administrator and will contain the following: (i) a general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous Denial); (ii) the date the IRO received the assignment to conduct External Review and the date of the Final External Review Decision; (iii) references to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching the decision; (iv) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied upon in making its decision; (v) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the claimant; (vi) a statement that judicial review may be available to the claimant; and (vii) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.
5. *Reversal of Plan's Decision.* If the Final Denial of the Plan is reversed by the Final External Review Decision, the Plan will immediately provide coverage or Payment (including immediately authorizing or immediately paying benefits) for a claim, upon receipt of notice of such reversal.
6. *Maintenance of Records.* The IROs will maintain records of all claims and notices associated with an External Review for 6 years. An IRO must make such records available for examination by the claimant, the Claims Administrator, or a State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Expedited External Review Process

1. *Application of Expedited External Review.* The Plan will allow the claimant to make a request for expedited External Review at the time the claimant receives either:
 - A Denial, if the Denial involves a medical condition of the claimant's for which the timeframe for completion of an internal appeal of an Urgent Care Claim would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an appeal of an Urgent Care Claim; or
 - A Final Denial, if the claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the claimant's life or health or would jeopardize the claimant's ability to regain maximum function, or if the Final Denial concerns admission, availability of care, continued stay, or a health care item or service for which the claimant received Emergency services, but has not been discharged from a facility.
2. *Preliminary Review.* Immediately upon receipt of a request for expedited External Review, the Claims Administrator must determine whether the request meets the reviewability requirements set forth in paragraph (1) above. The Claims Administrator will immediately send a notice that meets the requirements set forth above with respect to the preliminary review for standard External Review of the claimant for its eligibility determination.
3. *Referral to Independent Review Organization (IRO).* Upon a determination that a request is eligible for expedited External Review following the preliminary review, the Claims Administrator will assign an IRO pursuant to the requirements set forth above for standard External Review. The Claims Administrator must provide or transmit all necessary documents and information considered in making the Denial or Final Denial determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or

documents described above under the procedures for standard External Review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Claims Administrator's internal claims and appeals process.

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

Form and Manner of Notices

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

Effect of Federal Guidance on this Section

Any information, processes, standards of review, or other elements that are required to be provided under this Section 12 shall be provided or applied only if the Plan is required to do so under applicable legal requirements and the U.S. Departments of Labor, Treasury, and Health and Human Services are currently enforcing such requirements. For these purposes, the Plan may rely fully on the U.S. Department of Labor Technical Release 2011-01, the U.S. Department of Labor Technical Release 2011-02, the June 24, 2011 amendment to the interim final regulations published July 23, 2010, and any subsequent guidance.

Chart of Time Limits for Claims and Internal Appeals

MAXIMUM TIME LIMITS FOR:	TYPE OF CLAIM		
	Urgent Care Claims	Pre-Service Claims	Post-Service Claims
Claims Administrator to decide initial claim (if no additional information is needed) (whether adverse or not)	No later than 72 hours after receipt of claim by the Claims Administrator	No later than 15 days after receipt of claim by the Claims Administrator	No later than 30 days after receipt of claim by the Claims Administrator
Extension of time by Plan for determining initial claim	None	One time 15-day extension allowed if (i) due to matters beyond Claims Administrator's control and (ii) Claims Administrator notifies claimant before end of initial 15-day time period of such extension and the date Claims Administrator expects to render decision. If extension is due to claimant's failure to submit information, notice will describe required information. <i>Note: Claims Administrator may or may not allow extension due to claimant's failure to provide needed information.</i>	One time 15-day extension allowed if (i) due to matters beyond Claims Administrator's control and (ii) Claims Administrator notifies claimant before end of initial 30-day time period of such extension and the date Claims Administrator expects to render decision. If extension is due to claimant's failure to submit information, notice will describe required information. <i>Note: Claims Administrator may or may not allow extension due to claimant's failure to provide needed information.</i>
Claims Administrator to notify claimant of information needed from claimant to decide initial claim, if not provided by claimant	No later than 24 hours after receipt of incomplete claim by Claims Administrator	N/A	N/A
Claims Administrator to notify claimant of claimant's failure to follow proper procedures	No later than 24 hours after receipt of improper claim by Claims Administrator	No later than 5 days after receipt of improper claim by Claims Administrator	N/A
Claimant to then provide needed information (if extension allowed by Plan)	Not less than 48 hours after receipt of notice from Claims Administrator	At least 45 days after receipt of notice from Claims Administrator <i>Note: Claims Administrator may or may not request needed information from claimant.</i>	At least 45 days after receipt of notice from Claims Administrator <i>Note: Claims Administrator may or may not request needed information from claimant.</i>
Claims Administrator to decide claim after requesting additional information and notifying claimant (if applicable)	No later than 48 hours after earlier of (i) Claims Administrator's receipt of additional information from claimant, or (ii) end of time period given to claimant to provide additional information (48 hours)	No later than 15 days after earlier of (i) Claims Administrator's receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days)	No later than 15 days after earlier of (i) Claims Administrator's receipt of additional information from claimant, if requested, or (ii) end of time period given to claimant to provide additional information (45 days)
Claimant to file appeal	180 days after receipt of Denial by claimant	180 days after receipt of Denial by claimant	180 days after receipt of Denial by claimant
Claims Administrator to decide appeal	72 hours after Claims Administrator's receipt of appeal from claimant	30 days after Claims Administrator's receipt of appeal from claimant.	60 days after Claims Administrator's receipt of appeal from claimant.

COORDINATION OF BENEFITS (COB)

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

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

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

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

COB DEFINITIONS

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

1. Plan includes: Group and non-group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non-group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

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

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

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

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

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

The following are non-Allowable expenses:

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

1. Except as provided in Paragraph 2 below, a Plan that does not contain a coordination of benefits

provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.

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

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

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

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

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

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
 - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
 - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
 - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The Plan covering the Custodial parent;
 - The Plan covering the spouse of the Custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of items 1 and 2. above will determine the order of benefits as if those individuals were the parents of the child.
4. For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouses plan, Rule 5 applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule in item 1 above to the Dependent child's parent(s) and the Dependent's spouse.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers You as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering You as a retired or laid-off employee is the Secondary Plan. The same would hold true if You are a Dependent of an active employee and You are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN (FOR HSA PLAN)

When a Member is covered under two or more Plans which together pay more than the Allowable expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Plan's benefit payments will not be affected when it is primary. However, when this Plan is secondary under the Order of Benefit Determination Rules, payment consideration will begin with this Plan's Allowable expense, deduct the Primary Plan's payment and then deduct any Deductibles, Coinsurance or Copayments.

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

EFFECT ON THE BENEFITS OF THIS PLAN (FOR PPO PLANS)

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

1. the Plan has paid or for whom the Plan have paid; or
2. any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

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

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

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

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

Determining the Allowable Expense When This Plan is Secondary to Medicare

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

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

SUBROGATION AND REIMBURSEMENT

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

Recovery

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

Subrogation

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

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

Reimbursement

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

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

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

Your Duties

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

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

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

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

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

GENERAL INFORMATION

Entire Agreement

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

Form or Content of Benefit Booklet

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

Circumstances Beyond the Control of the Plan

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

Protected Health Information Under HIPAA

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

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

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

The Plan may:

- Disclose Summary Health Information to the University, if the University requests the Summary Health Information for the purpose of:
 - Obtaining premium bids from health plans for providing health insurance coverage under the Plan or
 - Modifying, amending, or terminating the Plan.

"Summary Health Information" is as defined by 45 CFR § 164.504(a), as amended, which generally is information that may be individually identifiable health information, and:

- That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the University has provided health benefits under a group health plan; and
- From which the information described at § 164.514(b)(2)(i) of the Privacy Regulations has been deleted, except that the geographic information described in § 164.514(b)(2)(i)(B) of the Privacy Regulations need only be aggregated to the level of a five digit zip code.
- Disclose to the University information on whether an Individual is participating in the Plan, or is enrolled in, or has disenrolled from a health insurance issuer or HMO offered by the Plan.
- Disclose Protected Health Information to the University to carry out Plan administration functions that the University performs, consistent with these provisions.
- With an authorization from the Covered Employee, disclose Protected Health Information to the University for purposes related to the administration of other employee plans and fringe benefits sponsored by the University.
- Not permit a health insurance issuer or HMO with respect to the Plan to disclose Protected Health Information to the University except as permitted here.
- Not disclose (and may not permit a health insurance issuer or HMO to disclose) Protected Health Information to the University as otherwise permitted unless a statement is included in the Plan's notice of privacy practices that the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose Protected Health Information to the University.
- Not disclose Protected Health Information to the University for the purpose of employment-related actions or decisions or in connection with any other benefit or employee plan of the University.

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

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

The University agrees to:

- Not use or further disclose Protected Health Information other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the University provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the University with respect to such Protected Health Information, and that any such agents or subcontractors agree to implement reasonable and appropriate security measures to protect any Electronic Protected Health Information belonging to the Plan that is provided by the University;
- Not use or disclose Protected Health Information for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose Protected Health Information in connection with any other benefit or employee plan of the University unless authorized by an individual;
- Report to the Plan any Protected Health Information use or disclosure that is inconsistent with the uses or disclosures provided for here, or any Security Incident, of which it becomes aware;
- Make Protected Health Information available to an individual in accordance with HIPAA's access requirements pursuant to 45 CFR § 164.524;

- Make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
- Make internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- If feasible, return or destroy all Protected Health Information received from the Plan that the University still maintains in any form, and retain no copies of such Protected Health Information when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan; and
- Ensure that these separations and requirements are supported by reasonable and appropriate security measures.

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

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

Legal Compliance

Eligibility for Medicaid

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

Workers' Compensation

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

Other Government Programs

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

Medicare Program

When You are eligible for the Medicare program and Medicare is allowed by federal law to be the primary payer, the benefits described in this Benefit Description will be reduced by the amount of benefits allowed under Medicare for the same covered services. This reduction will be made whether or not You actually receive the benefits from Medicare. For the purposes of the calculation of benefits, if the Covered Person has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled. If You do not enroll in Medicare Part B when You are eligible, You may have large out-of-pocket costs. Please refer to [Medicare.gov](https://www.medicare.gov) for more details on when You should enroll, and when You are allowed to delay enrollment without penalties.

- **If You Are Under Age 65 With End Stage Renal Disease (ESRD)**
If You are under age 65 and eligible for Medicare only because of ESRD (permanent kidney failure), the Plan will provide the benefits described in this Benefit Description before Medicare benefits. This includes the Medicare "three month waiting period" and the additional **30 months** after the Medicare effective date. After 33 months, the benefits described in this Benefit Booklet will be reduced by the amount that Medicare allows for the same covered services.
- **If You Are Under Age 65 With Other Disability**
If You are under age 65 and eligible for Medicare only because of a disability other than ESRD, the Plan will provide the benefits described in this Benefit Booklet before Medicare benefits. This is the case **only** if You are the actively employed Covered Person or the enrolled Spouse or child of the actively employed Covered Person.
- **If You Are Age 65 or Older**
If You are age 65 or older and eligible for Medicare only because of age, the Plan will provide the benefits described in this Benefit Booklet before Medicare. This can be the case **only** if You are an actively employed Covered Person or the enrolled Spouse of the actively employed Covered Person.

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.

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

Disputed Claims

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

Relationship of Parties (University-Covered Person-Claims Administrator)

Neither the University nor any Covered Person is the agent or representative of the Claims Administrator.

The University is an agent of the Covered Person. The Claims Administrator's notice to the University will constitute effective notice to the Covered Person. It is the University's duty to notify the Claims Administrator of eligibility data in a timely manner. The Claims Administrator is not responsible for payment of Covered Services of Covered Persons if the University fails to provide the Claims Administrator with timely notification of Covered Person enrollments or terminations.

Anthem Insurance Companies, Inc. Note

The University, on behalf of itself and its Covered Persons, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the University and Anthem Insurance Companies Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of the Administrative Services Agreement or this Benefit Booklet.

Notice

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

Modifications or Changes in Coverage

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

Fraud

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

Acts Beyond Reasonable Control (Force Majeure)

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

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

Conformity with Law

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

Clerical Error

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

Policies and Procedures

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

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

Value-Added Programs

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

Waiver

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

Reservation of Discretionary Authority

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

Payment Innovation Programs

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

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

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

Care Coordination

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

Program Incentives

The Plan may offer incentives from time to time, at its discretion, in order to introduce You to covered programs and services 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 the Plan offers the incentives program. The Plan may discontinue an incentive for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, it is recommended that You consult Your tax advisor.

Confidentiality and Release of Information

Applicable state and Federal law requires us to undertake efforts to safeguard Your medical information. For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of Your medical information is available on our website and can be furnished to You upon request by contacting our Member Services department. Obligations that arise under state and Federal law and policies and procedures relating to privacy that are referenced but not included in this Benefit Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

WHEN COVERAGE TERMINATES

Termination of Coverage

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

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

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

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

Approved Leaves of Absence

In the event of an approved paid or unpaid leave of absence by the University, coverage will terminate or continue pursuant to the University's leave policies and, if continued, the Covered Person will be responsible for the cost provided under those policies; provided, however, if the leave is an FMLA leave, the Covered Person is only responsible for the share of the premium for an active Eligible Employee; and provided further that coverage shall not terminate if the Covered Person is a Full-Time Employee, defined and determined in accordance with Appendix A.

Continuation of Coverage (COBRA)

If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with federal law. If Your employment is terminated for any reason other than gross misconduct, You may elect continuation coverage. You should contact the University if You have any questions about Your COBRA rights.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when Your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." An Eligible Employee, a Spouse and Dependent Children could become qualified beneficiaries if covered on the day before the qualifying event and coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

Each member of Your family who is enrolled in the Plan can elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. An Eligible Employee who is a Covered Person may elect COBRA continuation coverage on behalf of his or her Spouse, and parents or legal guardians may elect COBRA continuation coverage on behalf of their Dependent Children. A child born to, or placed for adoption with, an Eligible Employee during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
<u>For Employees:</u> Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
<u>For Spouses/ Dependent Children:</u> A Covered Employee's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked Eligible Employee's Entitlement to Medicare Divorce or Legal Separation from Eligible Employee Death of an Eligible Employee	18 months 36 months 36 months 36 months
<u>For Dependent Children:</u> Loss of Dependent Child Status	36 months

Second Qualifying Event

Continuation coverage stops before the end of the maximum continuation period if the Covered Person becomes entitled to Medicare benefits. If a continuing beneficiary becomes entitled to Medicare benefits, then a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if You become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for Your Spouse and Dependent Children can last up to 36 months after the date of Medicare entitlement.).

If Your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, Your Spouse and Dependent Children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused Your Spouse or Dependent Children to lose coverage under the Plan had the first qualifying event not occurred. A qualified beneficiary must give timely notice to the Plan Administrator in such a situation.

Notification Requirements

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

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

For Eligible Employees who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Eligible Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. The Eligible Employees' Dependents are also eligible for the 18 to 29-month disability extension. (This provision also applies if any covered family member is found to be disabled.) This provision would only apply if the qualified beneficiary provides notice of disability status within 60 days of the disabling determination. In these cases, the University can charge 150% of the premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

When COBRA Coverage Ends

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

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

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

Continuation of Coverage During Military Leave (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Covered Person may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Eligible Employee (or his or her Dependents) is covered under this Plan, and if the Eligible Employee becomes absent from employment by reason of military leave, the Eligible Employee (or his or her Dependents) may have the right to elect to continue health coverage under the Plan. In order to be eligible for coverage during the period that the Eligible Employee is gone on military leave, the Eligible Employee must give reasonable notice to the University of his or her military leave. The Eligible Employee will be entitled to COBRA-like rights with respect to his or her medical benefits in that the Eligible Employee

and his or her Dependents can elect to continue coverage under the Plan for a period of 24 months from the date the military leave commences or, if sooner, the period ending on the day after the deadline for the Eligible Employee to apply for or return to work with the University. During military leave the Eligible Employee is required to pay the University for the entire cost of such coverage, including any elected Dependents' coverage. However, if the Eligible Employee's absence is less than 31 days, the University must continue to pay its portion of the premiums and the Eligible Employee is only required to pay his or her share of the premiums without the COBRA-type 2% administrative surcharge.

Also, when the Eligible Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the University must waive any exclusions and waiting periods, even if the Eligible Employee did not elect COBRA continuation. These requirements are (i) the Eligible Employee gave reasonable notice to his or her University of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally 5 years, except in unusual or extraordinary circumstances) and the Eligible Employee must have received no less than an honorable discharge (or, in the case of an officer, not been sentenced to a correctional institution), and (iii) the Eligible Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Eligible Employee may also have to provide documentation to the University upon reemployment that would confirm eligibility. This protection applies to the Eligible Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Eligible Employee's reinstatement of coverage.

Continuation of Coverage Due to Family and Medical Leave (FMLA)

An Eligible Employee may continue coverage under the Plan as provided by the Family and Medical Leave Act (FMLA). An Eligible Employee who has been employed at least one year within the previous 12 months may elect to take an unpaid leave for up to 12 weeks in a 12-month period for the following reasons:

- The birth of the Eligible Employee's child.
- The placement of a child with the Eligible Employee for the purpose of adoption or foster care.
- To care for a seriously ill Spouse, child or parent.
- A serious health condition rendering the Eligible Employee unable to perform his or her job.

In addition, any spouse, son, daughter, parent, or nearest blood relative ("next of kin") of a "covered service member" will be granted leave not to exceed a total of 26 work weeks during a single 12 month period to care for the "covered service member." During the single 12-month period described above, a Covered Employee may be granted a combined total of 26 workweeks of leave for any combination of leaves under the FMLA. For purposes of this policy, the phrase "covered service member" means a Covered Employee of the Armed Forces, including a Covered Employee of the National Guard or Reserves, who is: (i) undergoing medical treatment, recuperation, or therapy; (ii) is otherwise in an "outpatient status" (as defined by regulations); or (iii) is otherwise on the temporary disability retired list, for a "serious injury or illness" (as defined by regulations).

If the Eligible Employee chooses to continue coverage during the leave, the Eligible Employee will be given the same health care benefits that would have been provided if the Eligible Employee were working, with the same premium. If the Eligible Employee's premium for continued coverage in the Plan is more than 30 days late, the University will send written notice to the Eligible Employee. It will tell the Eligible Employee that his or her coverage will be terminated and what the date of the termination will be if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If the Eligible Employee chooses not to continue coverage under the Plan during the leave, he or she will be immediately reinstated to the coverage under the Plan when the Eligible Employee returns from the FMLA leave. The Eligible Employee will not be required to meet any qualification requirements imposed by the Plan when he or she returns to work. This includes new or additional waiting periods, waiting for an open enrollment period, or passing a medical exam to reinstate coverage.

FMLA health care benefit coverages will terminate when:

- the Eligible Employee informs the University of his or her intent not to return from FMLA leave,
- the Eligible Employee fails to return from the FMLA leave, or
- the Eligible Employee exhausts his or her FMLA leave.

An Eligible Employee on FMLA leave are required to continue to pay required premiums, if any, toward coverage during the FMLA leave. If the FMLA leave is substituted by paid leave, premiums may be made by payroll deduction under the University's Flexible Benefits Plan or by whatever alternative method is normally utilized for making such premiums when the Eligible Employee is on paid leave. If the FMLA leave is unpaid leave, premiums may be made on a pay-as-you-go basis under the University's existing rules for payments by Eligible Employees on an unpaid leave. Payroll & Employee Benefits will invoice such Eligible Employee. Failure of an Eligible Employee to pay his or her share of premiums within 30 days after the due date will result in termination of coverage, provided the University has given the Eligible Employee 15 days advance written notice of the termination of coverage. If coverage ends due to the failure to make timely premiums, the Eligible Employee will be entitled to immediate reinstatement of health care coverages under the Plan on the Eligible Employee's return from the FMLA leave. Any changes by the University to an Eligible Employee's premiums will apply while the Eligible Employee is on FMLA leave.

The University may recover from the Eligible Employee its share of premiums made during a period of unpaid FMLA leave in order to maintain the Eligible Employee's coverage, if the Eligible Employee fails to return from work after a FMLA leave has been exhausted, unless the failure to return to work is due to a serious health condition of the Eligible Employee or a family member or other circumstances beyond the Eligible Employee's control. In addition, the University may recover from the Eligible Employee his or her share of the premiums which the University made on the Eligible Employee's behalf to maintain coverage, regardless of whether the Eligible Employee returns from FMLA leave.

Please contact Payroll & Employee Benefits for state specific Family and Medical Leave Act information.

DEFINITIONS

Actively at Work

An Eligible Employee who is capable of carrying out his or her regular job duties and who is present at his or her place of work, or who is absent from work due to a health related absence or disability.

Accidental Injury

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

Administrative Services Agreement

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

Ambulance Services

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

Authorized Service(s)

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

Behavioral Health Care

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

Mental Health Disorders

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

Substance Abuse or Chemical Dependency

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

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

Benefit Period

The 12 month period from January 1 to December 31 during which the Plan will pay benefits for Covered Services. It does not begin before a Covered Person's Effective Date and it ends when the Covered Person's coverage ends.

Centers of Excellence (COE) Network

A network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Covered Persons access select types of benefits through a specific network of medical centers.

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

Child or Children

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

Claims Administrator

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

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after You meet your Deductible. For example, if Your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, Your Coinsurance would be \$20 after You meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the **Schedule of Benefits** for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Combined Limit

The maximum total of Network and Out-of-Network benefits available for designated health services in the **Schedule of Benefits**.

Complications of Pregnancy

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

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

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

Congenital Anomaly

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

Coordination of Benefits

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

Copayment

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

Cosmetic Surgery

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

Covered Person

An Eligible Employee, or Dependent who has satisfied the Plan's eligibility conditions, applied for coverage, and enrolled in the Plan.

Covered Services

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

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

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

Covered Transplant Procedure

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

Custodial Care

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

Deductible

The dollar amount of Covered Services which you must pay before the Plan will pay for those Covered Services each Benefit Period. In-Network Deductibles and Out-of-Network Deductibles do accumulate toward each other.

Denial

A denial, reduction, termination or failure to provide or make Payment (in whole or in part) for a benefit, including determinations based on eligibility and utilization review, or a failure to cover a benefit because it is determined to be Experimental/Investigative or not Medically Necessary. It also means a Rescission of coverage whether or not, in connection with the Rescission, there is an adverse effect on any particular benefit at that time.

Dependent

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

Detoxification

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

Developmental Delay

The statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

Diagnostic

A test or procedure performed on a Covered Person who is displaying specific symptoms to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for a Covered Person who is not displaying any symptoms.

Durable Medical Equipment

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

Effective Date

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

Elective Surgical Procedure

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

Electronic Protected Health Information or EPHI

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

Eligible Employee

An Eligible Employee includes:

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

An Eligible Employee shall continue to be an Eligible Employee if he or she (i) is eligible for and receives long-term disability benefits under the University's long term disability program or (ii) is on an approved sick or parental leave with the University pursuant to its leave policy, but for no longer than the following periods:

(1) two years, if he or she has at least one but less than five years of service with the University; (2) three years, if he or she has at least five but less than ten years of service with the University or (3) through the end of the fiscal year in which he or she attains age 66, if he or she has ten or more years of service with the University.

An Eligible Employee does not include:

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

Emergency Medical Services Provider Organization

A provider of Emergency medical services that is certified by the Indiana emergency medical services commission as an advanced life support provider organization under Indiana law.

Emergency Medical Condition (“Emergency Services,” “Emergency Care,” or “Medical Emergency”)

Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Experimental/Investigative

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

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

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

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

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

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

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

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

External Review

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

Final Denial

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

Final External Review Decision

A determination by an Independent Review Organization at the conclusion of External Review.

Freestanding Ambulatory Facility

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis (no patients stay overnight). The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed and accredited by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

Health Care Operations

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

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

Health Care Professional

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

HIPAA

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

Home Health Care

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

Home Health Care Agency

A Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

Hospice

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

Hospice Care Program

A coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed and accredited by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

Hospital

An institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care facility; nursing home; place for rest; facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

Identification Card

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

Independent Review Organization (IRO)

An entity that conducts independent External Reviews of Denials and Final Denials.

Ineligible Charges

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

Ineligible Provider

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

Infertile or Infertility

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

Injury

Bodily harm from a non-occupational accident.

Inpatient

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

Intensive Care Unit

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

Intensive Outpatient Programs

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

Maternity Care

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

Maximum Allowed Amount

The maximum amount that the Plan will allow for Covered Services You receive. For more information, see the "Claims Payment" section.

Medical Facility

A facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Benefit Booklet. The facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

Medical Necessity or Medically Necessary

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

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

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

Network Provider

A Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Covered Persons through negotiated reimbursement arrangements. A Network Provider for one plan may not be a Network Provider for another. Please see "How to Find a Provider in the Network" in the section **How Your Plan Works** for more information on how to find a Network Provider for this Plan.

Non-Covered Services

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

Out-of-Network Provider

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

Out-of-Pocket Maximum

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

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.

Payment

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

- Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and Copayments as determined for a Covered Person's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other Payment disputes);
- Subrogation of health benefit claims;
- Establishing contributions;
- Risk adjusting amounts due based on a Covered Person's health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing Payments, investigating and resolving Payment disputes and responding to a Covered Person's inquiries about Payments;
- Obtaining Payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
- Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;

- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for Payment purposes: name and address, date of birth, Social Security number, Payment history, account number and name and address of the Provider and/or health plan);
- Reimbursement to the Plan; and
- Any other activity considered to be a "Payment" activity pursuant to 45 CFR § 164.501.

Pharmacy

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

Physical Therapy

The care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

Physician

Any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

Plan

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

Plan Administrator

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

Plan Sponsor

Ball State University.

Post-Service Claim

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

PPACA

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

Pre-Service Claim

Any claim whereby the Plan conditions receipt of such benefit, in whole in part, on approval of the benefit prior to obtaining medical care.

Prior Authorization

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

Protected Health Information

"Protected health information" as defined at 45 CFR § 164.501 which, generally, means information (including demographic information) that (i) identifies an individual (or with respect to which there is a reasonable basis to believe the information can be used to identify an individual), (ii) is created or received by a health care provider, a health plan, or a health care clearinghouse, and (iii) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future Payment for the provision of health care to an individual.

Provider

A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services that are required by applicable state law to be covered when rendered by such Provider.

QMCSO or MCSO – Qualified Medical Child Support Order or Medical Child Support Order

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

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

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

Rescission or Rescind

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

Residential Treatment Center/Facility

A Provider licensed and operated as required by law, which includes:

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

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care

- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

Retail Health Clinic

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

Security Incident

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

Semiprivate Room

A Hospital room that contains two or more beds.

Skilled Convalescent Care

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

Skilled Nursing Facility

An institution operated alone or with a Hospital that gives care after a Covered Person leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

Specialist (Specialty Care Physician\Provider or SCP)

A Specialist is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Spouse

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

Telehealth

Consultations with your physician (PCP/Specialist) using visual and audio (Computer, Smart Phone, Tablet).

Telephonic

Consultations with your physician (PCP/Specialist) using audio only (telephone).

Therapeutic Equivalent

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

Transplant Providers

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

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

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

University

Ball State University.

Urgent Care

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

Urgent Care Claim

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

Utilization Review

Evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services.

You and Your

Refer to a Covered Person.

HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

Statement of Rights Under the Newborns' and Mother's Health Protection Act

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

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

Statement of Rights Under the Women's Cancer Rights Act of 1998

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

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

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

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

Coverage for a Child Due to a Qualified Medical Support Order (“QMCSO”)

If You or Your spouse are required, due to a QMCSO, to provide coverage for Your child(ren), You may ask the University or Plan Administrator to provide You, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

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

PLAN INFORMATION

- **Plan Name:** Ball State University Group Health Plan
- **Plan Sponsor:** Ball State University
2000 University Avenue
Muncie, IN 47306
- **University I.D. Number:** 35-6000221
- **Type of Plan:** The Plan is an employee welfare benefit plan providing group medical benefits.
- **Plan Year Ends:** December 31
- **Type of Administration/Funding:** Medical benefits are self-funded by the University and claims are administered by Anthem Blue Cross Blue Shield (IN) on behalf of the University
- **Plan Administrator:** Ball State University
- **Agent for Service of Legal Process:** Ball State University

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Company (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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 Identification 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, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. 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>.

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 Identification 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 Member Services 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)

Albanian

Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Arabic

فبإمكانكم الحصول على هذه المعلومات والمساعدة مجاناً بلغة أمكم. إن أجبت عن استفساراتكم، سنساعدكم في الحصول على المعلومات والمساعدة مجاناً. (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)

Bassa

Má fdf dvi-6èdèin-dèò 6é m'kf bō nia ks-ke gbo-kpb- kpb dvi df m'bidì-wùduùn 6p-nidvi-Db m'pà-je gbo-gm's kpoè n'ba nia nì Dy)-dyoia-bé 5 k's é bé m'kf gbo-kpb-kpb dvi. (TTY/TDD: 711)

Bengali

আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Burmese

ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိခွင့် သင့်တွင်ရှိပါသည်။
အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။
(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)

Dinka

Yin noŋ yic ba ye lëk në yök ku bë yi kuony në thöŋ yin jām ke cin wëu töu kē piiny. Cɔl rän töŋ dë kɔc kē luoi në namba dën tönë I.D kat du yic. (TTY/TDD: 711)

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstnummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi

لەمش نیایا هەک دیراد ار قح نیایا تاعلاطا ار لههکمک و تروص هه به ناگیار
نابز ناتدوخ تفایرد .مدینک یارب تفایرد هه به کمک ه رالمش زکرم تامدخ اعضدا
رب هه ک یور تراک ناتییاسانش جرد هه دش ،تسا سهاست بگیریډ. (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)

German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (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)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo

Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano

Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian

Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (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)

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)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ: នឹងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi

Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (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)

Lao

ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ.
(TTY/TDD: 711)

Navajo

Bee ná ahoot'í' t'áá ni nizaad k'ehjí níká á a'doowol t'áá jíík'e.
Naaltsoos bee atah nílínígíí bee néé'ho'dólzingo nanitinígíí béésh bee
hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee
néé'ho'dólzingo nanitinígíí béésh bee hane'í bikáá' áají' hodíílnih.
(TTY/TDD: 711)

Nepali

तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo

Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda.
Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa
enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch

Du hoscht die Recht selle Information un Hilfe in dei Schprooch mitaus Koscht griege.
Ruf die Member Services Nummer uff dei ID Kaarte fer Hilfe aa. (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)

Portuguese-Europe

Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue
para o número dos Serviços para Membros indicado no seu cartão de identificação para
obter ajuda. (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)

Romanian

Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apăsați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (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)

Samoan

E iai lou 'aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totoi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian

Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (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)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian

Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu

آپ کو اپنی زبان میں مفت ان معلومات اور مدد کے حصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (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)

Yiddish

רופט די מעמבער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם.
באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba

O ní ètọ́ láti gba ìwífún yíí kí o sì şèrànwọ́ ní èdè rẹ̀ lọfẹ́ẹ́. Pe Nọmbà àwọn ipèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ́ rẹ̀ fún ìrànwọ́. (TTY/TDD: 711)