MEDICAL BENEFIT BOOKLET

For

UNIVERSITY OF CINCINNATI
Active Employee PPO Medical Plan
Package 006

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 Customer Service at the number on Your Identification Card.

Effective 1/1/2016
BENEFIT BOOKLET

This Benefit Booklet provides You with a description of Your benefits while You are enrolled under the health care plan (the "Plan") offered by Your Employer. You should read this 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 Your Employer’s Group Health Plan Administrator or call the Claims Administrator’s Customer Service Department.

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

Anthem Blue Cross and Blue Shield, or "Anthem" has been designated by Your Employer to provide administrative services for the Employer’s Group Health 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 Employer 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 Ohio. Although Anthem is the Claims Administrator and is licensed in Ohio, 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 Employer on its own behalf and not as the agent of the Association.

 Verification of Benefits
Verification of Benefits is available for Members or authorized healthcare Providers on behalf of Members. You may call Customer Service 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 CUSTOMER SERVICE NUMBER ON YOUR IDENTIFICATION CARD or see the section titled Health Care Management for Precertification rules.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>BENEFIT BOOKLET</td>
<td>2</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>3</td>
</tr>
<tr>
<td>MEMBER RIGHTS AND RESPONSIBILITIES</td>
<td>4</td>
</tr>
<tr>
<td>SCHEDULE OF BENEFITS</td>
<td>6</td>
</tr>
<tr>
<td>TOTAL HEALTH AND WELLNESS SOLUTION</td>
<td>19</td>
</tr>
<tr>
<td>ELIGIBILITY</td>
<td>21</td>
</tr>
<tr>
<td>HOW YOUR PLAN WORKS</td>
<td>24</td>
</tr>
<tr>
<td>HEALTH CARE MANAGEMENT - PRECERTIFICATION</td>
<td>27</td>
</tr>
<tr>
<td>BENEFITS</td>
<td>34</td>
</tr>
<tr>
<td>LIMITATIONS AND EXCLUSIONS</td>
<td>52</td>
</tr>
<tr>
<td>CLAIMS PAYMENT</td>
<td>58</td>
</tr>
<tr>
<td>YOUR RIGHT TO APPEAL</td>
<td>65</td>
</tr>
<tr>
<td>COORDINATION OF BENEFITS (COB)</td>
<td>73</td>
</tr>
<tr>
<td>SUBROGATION AND REIMBURSEMENT</td>
<td>78</td>
</tr>
<tr>
<td>GENERAL INFORMATION</td>
<td>80</td>
</tr>
<tr>
<td>WHEN COVERAGE TERMINATES</td>
<td>85</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>90</td>
</tr>
<tr>
<td>HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW</td>
<td>102</td>
</tr>
</tbody>
</table>
MEMBER 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 members about their health plan, regardless of their language. Anthem employs a Language Line interpretation service for use by all of our Customer Service Call Centers. Simply call the Customer Service phone number on the back of your ID Card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting customer service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.
SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet its definition of Covered Services, as long as such services and supplies are not excluded under the Member's Plan, are Medically Necessary, and are provided in accordance with the Member's 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.

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$100</td>
<td>$400</td>
</tr>
<tr>
<td>Family</td>
<td>$200</td>
<td>$800</td>
</tr>
</tbody>
</table>

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

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

Your Plan has an embedded Deductible which means:

- If You, the Subscriber, are the only person covered by this Plan, only the “Individual” amounts apply to You.
- If You also cover Dependents (other family members) under this Plan, both the “Individual” and the “Family” amounts apply. The “Family” Deductible amounts can be satisfied by any combination of family members but You could satisfy Your own “Individual” Deductible amount before the “Family” amount is met. You will never have to satisfy more than Your own ‘Individual” Deductible amount. If You meet Your “Individual” Deductible amount, Your other family member’s claims will still accumulate towards their own “Individual” Deductible and the overall “Family” amounts. This continues until Your other family members meet their own “Individual” Deductible or the entire “Family” Deductible is met.

The Network and Out-of-Network calendar year Deductibles are separate and cannot be combined.

<table>
<thead>
<tr>
<th>Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Pays</td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td>Member Pays</td>
<td>10%</td>
<td>30%</td>
</tr>
</tbody>
</table>

All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.
<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket Maximum Per Calendar Year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Coinsurance and the calendar year Deductible for <em>Medical only</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,100</td>
<td>$1,100</td>
</tr>
<tr>
<td>Family</td>
<td>$2,200</td>
<td>$2,200</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum Per Calendar Year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Coinsurance and Copayments, calendar year Deductible and Prescription Drugs. Does NOT include Pre-certification penalties, and services deemed not Medically Necessary by Medical Management and/or Anthem and charges in excess of the Maximum Allowed Amount or Non-Covered Services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,850</td>
<td>N/A</td>
</tr>
<tr>
<td>Family</td>
<td>$13,700</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*Your Plan has an embedded Out-of-Pocket which means:*

- If You, the Subscriber, are the only person covered by this Plan, only the “Individual” amounts apply to You.
- If You also cover Dependents (other family members) under this Plan, both the “Individual” and “Family” amounts apply. The “Family” Out-of-Pocket amounts can be satisfied by any combination of family members but You could satisfy Your own “Individual” Out-of-Pocket amount before the “Family” amount is met. You will never have to satisfy more than Your own “Individual” Out-of-Pocket amount. If You meet Your “Individual” amount, other family member’s claims will still accumulate towards their own “Individual” Out-of-Pocket and the overall “Family” amounts. This continues until Your other family members meet their own “Individual” Out-of-Pocket or the entire “Family” Out-of-Pocket is met.

The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined.

Note: Medical Out-of-Pocket does not apply to the pharmacy Out-of-Pocket. The pharmacy Out-of-Pocket for an individual is $6,850 per person per Calendar Year. The combined Family maximum Out-of-Pocket (medical and pharmacy) is $13,700 per family per Calendar Year.

The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Note:</strong> Copayments only apply to certain Network services and are not applicable to Out-of-Network services unless otherwise noted. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Allergy Care</strong></td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Allergy injections and serums</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health / Substance Abuse Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Precertification required)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient / Rehabilitation / Detox</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Physician Hospital services</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient / Rehabilitation / Detox</td>
<td>$20 Copayment (Deductible does not apply)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Professional</td>
<td>$20 Copayment (Deductible does not apply)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td><strong>ADD/ADHD</strong></td>
<td>Covered at the benefit level of the services billed</td>
<td>Covered at the benefit level of the services billed</td>
</tr>
<tr>
<td>• Includes Autistic Disease, Mental Retardation, Developmental Delays and Learning Disabilities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
</tr>
<tr>
<td>Please see Clinical Trials under Benefits section for further information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental &amp; Oral Surgery / TMJ Services</strong></td>
<td>Covered at the benefit level of the services billed</td>
<td>Covered at the benefit level of the services billed</td>
</tr>
<tr>
<td>• Accidental Injury to natural teeth (Treatment must begin within 90 days of the accident and treatment must be completed within 12 months of the accident).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral Surgery - Subject to Medical Necessity</strong></td>
<td>Covered at the surgical level</td>
<td>Covered at the surgical level</td>
</tr>
<tr>
<td>• excludes appliances and orthodontic treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• includes removal of impacted teeth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Benefits | Network | Out-of-Network
--- | --- | ---

**Note:** Copayments only apply to certain Network services and are not applicable to Out-of-Network services unless otherwise noted. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.

- **TMJ - Subject to Medical Necessity** – excludes appliances and orthodontic treatment.
  - Covered for medical treatment (surgical and non-surgical).
  - Appliances are not covered.
  - Surgical TMJ services are covered at 10% Coinsurance after Deductible, in Network.  
  
  Covered at the benefit level of the services billed.  
  Covered at the benefit level of the services billed.

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**Diagnostic Physician’s Services**

Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:

- Primary care Physician Copayment/Coinsurance
- Specialist Physician Copayment/Coinsurance
- Primary care UC Physician Copayment/Coinsurance
- Specialist UC Physician Copayment/Coinsurance
- Diagnostic X-ray and Lab – office or independent lab (Network not subject to the Deductible)

<table>
<thead>
<tr>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15 Copayment</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>$20 Copayment</td>
<td></td>
</tr>
<tr>
<td>$7.50 Copayment</td>
<td></td>
</tr>
<tr>
<td>$10 Copayment</td>
<td></td>
</tr>
<tr>
<td>10% Coinsurance (Deductible applies)</td>
<td></td>
</tr>
</tbody>
</table>

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

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

- **Emergency room for an Emergency Medical Condition**
  - All other services
  - Copayment waived if admitted

<table>
<thead>
<tr>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$75 Copayment (Deductible does not apply)</td>
<td>Covered at the in Network benefit level (See note next page)</td>
</tr>
</tbody>
</table>

- **Emergency Room Physician**

<table>
<thead>
<tr>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% Coinsurance (Deductible applies)</td>
<td>Covered at the in Network benefit level (See note next page)</td>
</tr>
</tbody>
</table>

- **Emergency room for a Non-Emergency Medical Condition**
  - All other services
  - Copayment applies to ER service only

<table>
<thead>
<tr>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$75 Copayment (Deductible does not apply)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>Benefits</td>
<td>Network</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td><strong>Note:</strong> Copayments only apply to certain Network services and are not applicable to Out-of-Network services unless otherwise noted. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Medical Condition - Emergency Room Physician 10% Coinsurance (Deductible applies) 30% Coinsurance (Deductible applies)</td>
<td></td>
</tr>
<tr>
<td>Urgent Care clinic visit – Institutional and Professional $20 Copayment, then Covered at 100%</td>
<td></td>
</tr>
<tr>
<td>Ambulance Services (when Medically Necessary) Land / Air 10% Coinsurance (Deductible applies)</td>
<td>Covered at the in Network benefit level (See note below)</td>
</tr>
<tr>
<td><strong>Note:</strong> 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.</td>
<td></td>
</tr>
<tr>
<td><strong>Eye Care Non Routine</strong></td>
<td></td>
</tr>
<tr>
<td>• Office visit – medical eye care exams (treatment of disease or Injury to the eye) $15 Copayment 30% Coinsurance (Deductible applies)</td>
<td></td>
</tr>
<tr>
<td>▶ Primary care Physician</td>
<td></td>
</tr>
<tr>
<td>▶ Specialist Physician</td>
<td></td>
</tr>
<tr>
<td>▶ Primary care UC Physician</td>
<td>$7.50 Copayment 30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>▶ Specialist UC Physician</td>
<td></td>
</tr>
<tr>
<td>• Treatment other than office visit $10 Copayment 30% Coinsurance (Deductible applies)</td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Care Non Routine</strong></td>
<td></td>
</tr>
<tr>
<td>▶ Office visit – Audiometric exam / hearing evaluation test $15 Copayment 30% Coinsurance (Deductible applies)</td>
<td></td>
</tr>
<tr>
<td>▶ Primary care Physician</td>
<td></td>
</tr>
<tr>
<td>▶ Specialist Physician</td>
<td></td>
</tr>
<tr>
<td>▶ Primary care UC Physician</td>
<td>$7.50 Copayment 30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>▶ Specialist UC Physician</td>
<td></td>
</tr>
</tbody>
</table>

University of Cincinnati
Active Employee PPO Medical Plan
Package 006
Effective January 1, 2016
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services unless otherwise noted. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>► Treatment other than office visit</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>► Hearing devices / hearing aids are not covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing only covered in the home.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Includes Home Infusion Therapy</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td><strong>Hospice Care Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Bereavement is not covered.</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Respite Care is covered.</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td><strong>Hospital Inpatient Services – Precertification Required</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Room and board (Semiprivate or ICU/CCU)</td>
<td>10% Coinsurance per admission (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Hospital services and supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient Physical Therapy, etc.)</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Inpatient Physical Medicine</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Skilled Nursing Care Facility</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Pre-Admission testing</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Physician Services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>► Surgeon</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>► Anesthesiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>► Radiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>► Pathologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services. *<em>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.</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>----------</td>
<td>---------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Note:</strong> Copayments only apply to certain Network services and are not applicable to Out-of-Network services unless otherwise noted. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Maternity Care & Other Reproductive Services
(Dependent Daughters are covered.)

- **Physician’s office:**
  Global care (includes pre-and post-natal, delivery) – Copayment (first visit):

  - First prenatal visit is subject to:
    - $15 office visit Copayment
    - $7.50 Copayment UC Physician

  **30% Coinsurance (Deductible applies)**

### Physician Hospital / Birthing Center Services
(Precertification required)

- **Physician’s services**
- **Newborn nursery services (well baby care)**
- **Circumcision**

  **10% Coinsurance (Deductible applies)**

  **30% Coinsurance (Deductible applies)**

**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.

### Infertility Services

Services are covered for the diagnosis of infertility, up to 3 series of 9 infertility injectable drugs plus 1 injection of Human Chorionic Gonadotropin along with office visit charges, testing and labs related to covered injections.

- **Infertility Treatment -- Artificial Insemination**
- **Infertility Treatment - including in-vitro fertilization, GIFT (gamete intrafallopian transfer), or ZIFT (zygot intra-fallopian transfer) procedures.**

  **Not Covered**
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services unless otherwise noted. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</td>
<td>10% Coinsurance</td>
<td>30% Coinsurance</td>
</tr>
<tr>
<td>Voluntary sterilization - services that do not meet Women's Health Provision requirement. (Precertification required for Inpatient procedures)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Vasectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reversals are not covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section in Benefits for further details.</td>
<td>Covered at the benefit level of the services billed</td>
<td>Covered at the benefit level of the services billed</td>
</tr>
<tr>
<td>Contraceptives Not included in Women’s Health Provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Spermicide, vaginal ring, hormone patch, Depo -Estradiol Cypionate - up to 5 MG, and other covered contraceptives included in Women’s Health provision but not meeting required Women’s Health diagnosis restrictions.</td>
<td>20% Coinsurance (Deductible does not apply)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>Medical Supplies and Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical Supplies</td>
<td>20% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Diabetic Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Diabetic Supplies covered by pharmacy plan are not covered under medical – including lancets, syringes, insulin, etc.</td>
<td>20% Coinsurance (Deductible does not apply)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>– Diabetic supplies not covered under Pharmacy are covered by the medical plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Durable Medical Equipment (Purchase &amp; Rental)</td>
<td>20% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Orthotics</td>
<td>20% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>Foot and Shoe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prosthetic Appliances</td>
<td>20% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>– Includes initial glasses or contact lenses after cataract surgery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Wigs/Toupees limited to 1 per lifetime, subject to Medical Necessity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling for Diabetes and Weight Loss</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>Benefits</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services unless otherwise noted. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Hospital / Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient facility</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Lab and x-ray services non routine</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Outpatient Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td><strong>Physician Services (Home and Office Visits)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Primary care Physician Copayment (per visit)</td>
<td>$15 Copayment</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Specialist Physician Copayment (per visit)</td>
<td>$20 Copayment</td>
<td></td>
</tr>
<tr>
<td>• Primary care UC Physician Copayment (per visit)</td>
<td>$7.50 Copayment</td>
<td></td>
</tr>
<tr>
<td>• UC Specialist Physician Copayment (per visit)</td>
<td>$10 Copayment</td>
<td></td>
</tr>
<tr>
<td>Online Visit</td>
<td>$15 Copayment</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>Office Surgery</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td><strong>Prescription Injectables / Prescription Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dispensed in the Physician’s Office, except allergy</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td><strong>Preventive Services (regardless of Provider or setting where Preventive care is provided)</strong></td>
<td>Covered at 100%</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td><strong>Includes Women's Heath Provision. Covered based on the diagnosis restriction within the Women’s Health provision.</strong></td>
<td>Covered at 100%</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td><strong>Birth Control- covered under Women's Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUDs, injections for Depo-Provera, diaphragm fittings, and any other FDA approved birth control devices (other than the ones listed above as not included in Women's Health). Covered based on the diagnosis restriction within the Women’s Health provision.</td>
<td>Covered at 100%</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td><strong>Routine Vision and Hearing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>Benefits</td>
<td>Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Note: Copayments only apply to certain Network services and are not applicable to Out-of-Network services unless otherwise noted. When a Copayment applies, the Deductible is waived. Unless otherwise noted, Out-of-Network services are subject to the applicable Deductible and Coinsurance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Services</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• Bariatric Surgery</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Therapy Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>$20 Copayment</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td></td>
<td>$10 Copayment UC</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy, Occupational Therapy and Speech Therapy</td>
<td>60 visits combined with Occupational Therapy and Speech Therapy per calendar year combined Institutional/Professional Network and Out-of-Network.</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>20 visits per calendar year (includes all services performed by a chiropractor except Labs and X-Rays) Combined Network and Out-of-Network</td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• No visit limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• No visit limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• No visit limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>30% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>• No visit limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Therapy</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Note: Inpatient therapy services will be paid under the Inpatient Hospital benefit.
<table>
<thead>
<tr>
<th>Transplants</th>
<th>Center of Excellence</th>
<th>Network Transplant Provider</th>
<th>Out-of-Network Transplant Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy.</td>
<td>Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Transplant Provider agreement. Contact the Customer Service number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)</td>
<td>Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.</td>
<td></td>
</tr>
</tbody>
</table>

**The Center of Excellence requirements do not apply to** Cornea and kidney transplants and any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. **Note:** Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers. (When calling Customer Service, ask to be connected with the Transplant Case Manager for further information.)

<table>
<thead>
<tr>
<th>Transplant Benefit Period</th>
<th>Covered at 100%</th>
<th>10% Coinsurance (Deductible applies)</th>
<th>50% Coinsurance (Deductible applies)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered Transplant Procedure during the Transplant Benefit Period</strong></td>
<td>Covered at 100%</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>50% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>- Care coordinated through a Network Transplant Provider/ Center of Excellence – not subject to Deductible</td>
<td>Covered at 100%</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>50% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>- When performed by Out-of-Network Transplant Provider (subject to Deductible, does not apply to the Out-of-Pocket Maximum). <strong>You are responsible for any charges from the Out-of-Network Transplant Provider which exceeds the Maximum Allowed Amount.</strong></td>
<td>Covered at 100%</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>50% Coinsurance (Deductible applies)</td>
</tr>
</tbody>
</table>

**Bone Marrow Donor Search Fee**
- Limited to $35,000 per transplant

<table>
<thead>
<tr>
<th>Bone Marrow Donor Search Fee</th>
<th>Covered at 100%</th>
<th>10% Coinsurance (Deductible applies)</th>
<th>50% Coinsurance (Deductible applies)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Covered at 100%</strong></td>
<td>Covered at 100%</td>
<td>10% Coinsurance (Deductible applies)</td>
<td>50% Coinsurance (Deductible applies)</td>
</tr>
<tr>
<td>Transplants</td>
<td>Center of Excellence</td>
<td>Network Transplant Provider</td>
<td>Out-of-Network Transplant Provider</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>----------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Eligible Travel and Lodging</td>
<td></td>
<td>10% Coinsurance (Deductible applies)</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• <strong>Lodging allowance</strong>: $50 per day for double occupancy. (Reimbursed at 100% as long as transplant is covered and performed at Center of Excellence facility)</td>
<td>Covered at 100%</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
</tr>
<tr>
<td>• Transportation for two companions if the patient is a minor child. No dollar limit amount per fare.</td>
<td></td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
<td></td>
</tr>
<tr>
<td>• Travel is reimbursed for patient and companion.</td>
<td></td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
<td></td>
</tr>
<tr>
<td>• Maximum: $10,000 per transplant.</td>
<td></td>
<td>Benefits are paid based on the setting in which Covered Services are received</td>
<td></td>
</tr>
</tbody>
</table>

| 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 |
| 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 |                                    |
| 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 |                                    |
### Prescription Drugs

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs – Retail Pharmacy Copayment (34-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tier 1 (Generic) – Copayment payable per Prescription</td>
<td>$15</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>• Tier 2 (Brand Formulary) – Copayment payable per Prescription</td>
<td>$25</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>• Tier 3 (Brand Non-Formulary) – Copayment payable per Prescription</td>
<td>$35</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>• Tier 4 – percentage payable per Prescription</td>
<td>25% Coinsurance with a $250 maximum per prescription</td>
<td>30% coinsurance with a $250 maximum per prescription</td>
</tr>
</tbody>
</table>

### Home Delivery (Mail Service) Prescription Drugs Copayment (90-day supply)

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs – Retail Pharmacy Copayment (34-day supply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Tier 1 (Generic) – Copayment payable per Prescription</td>
<td>$30</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Tier 2 (Brand Formulary) – Copayment payable per Prescription</td>
<td>$50</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Tier 3 (Brand Non-Formulary) – Copayment payable per Prescription</td>
<td>$70</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Tier 4 – percentage payable per Prescription</td>
<td>25% Coinsurance with a $250 maximum per prescription</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

**Note:** The available day supply may be less than the 34 or 90 days shown above due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

**Note:** A 30-day supply of a maintenance medicine may be filled two (2) times at a regular local pharmacy for the regular Copayment. After that, if a maintenance medicine is filled at a local pharmacy, the cost will be twice the regular Copayment.

**Note:** If You request a Brand Drug when a Generic Drug is available, You will be required to pay the difference in cost between the Brand and Generic Drug in addition to the Generic Copayment. If, however, the prescriber writes “Dispense as Written” or “Do not Substitute,” or if there is no Generic Drug available, You will only have to pay the Brand Copayment (preferred or non-preferred, as applicable).

**Note:** A limited number of Prescription Drugs require Prior Authorization for Medical Necessity. If Prior Authorization is not approved, then the designated drug will not be eligible for coverage. To determine if a drug requires Prior Authorization, please call Customer Service. If an Out-of-Network Pharmacy is used, the Member must file a claim for reimbursement; the Member may be responsible for the difference between the negotiated rate and the Pharmacy's actual charge.

**Note:** Certain diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments when obtained from a Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if obtained from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment.
TOTAL HEALTH AND WELLNESS SOLUTION

ConditionCare Programs
ConditionCare programs help maximize Your health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

• Asthma (pediatric and adult).
• Diabetes (pediatric and adult).
• Heart failure (HF).
• Coronary artery disease (CAD).
• Chronic obstructive pulmonary disease (COPD).

You’ll get:

• 24/7 phone access to a nurse coach who can answer Your questions and give You up-to-date information about Your condition.
• A health review and follow-up calls if You need them.
• Tips on prevention and lifestyle choices to help You improve Your quality of life.

Future Moms
The Future Moms program offers a guided course of care and treatment, leading to overall healthier outcomes for mothers and their newborns. Future Moms helps routine to high-risk expectant mothers focus on early prenatal interventions, risk assessments and education. The program includes special management emphasis for expectant mothers at highest risk for premature birth or other serious maternal issues. The program consists of nurse coaches, supported by pharmacists, registered dietitians, social workers and medical directors. You’ll get:

• 24/7 phone access to a nurse coach who can talk with You about Your pregnancy and answer Your questions.
• Your Pregnancy Week by Week, a book to show You what changes You can expect for You and Your baby over the next nine months.
• Useful tools to help You, Your doctor and Your Future Moms nurse coach track Your pregnancy and spot possible risks.

24/7 NurseLine
You may have emergencies or questions for nurses around-the-clock. 24/7 NurseLine provides You with accurate health information any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, You can make more informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

• A skilled clinical team – RN license (BSN preferred) that helps Members assess systems, understand medical conditions, ensure Members receive the right care in the right setting and refer You to programs and tools appropriate to Your condition.
• Bilingual RNs, language line and hearing impaired services.
• Access to the AudioHealth Library, containing hundreds of audiotapes on a wide variety of health topics.
• Proactive callbacks within 24 to 48 hours for Members referred to 911 emergency services, poison control and pediatric Members with needs identified as either emergent or urgent.
• Referrals to relevant community resources.
**MyHealth Advantage**

MyHealth Advantage is a free service that helps keep You and Your bank account healthier. Here’s how it works: the Claims Administrator review Your incoming health claims to see if we can save You any money. The Claims Administrator can check to see what medications You’re taking and alert Your doctor if we spot a potential drug interaction. The Claims Administrator also keep track of Your routine tests and checkups, reminding You to make these appointments by mailing You MyHealth Note. MyHealth Notes summarize Your recent claims. From time to time, The Claims Administrator offer tips to save You money on prescription drugs and other health care supplies.

**Voluntary Clinical Quality Programs**

The Claims Administrator may offer additional opportunities to assist You in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that You have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under this Plan. These programs are not guaranteed and could be discontinued at any time. The Plan may give You the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program’s timeframe, You may receive incentives such as gift cards. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If You receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to You. For additional guidance, please consult Your tax advisor.)
ELIGIBILITY

Members who do not enroll within 31 days of being eligible are considered Late Enrollees. Please refer to the “Late Enrollees” provision in this section.

Coverage for the Employee
This Benefit Booklet describes the benefits an Employee may receive under this health care Plan. The Employee is also called a Subscriber. The Employer makes all determinations regarding eligibility.

Coverage for the Employee’s Dependents
If the Employee is covered by this Plan, the Employee may enroll his or her eligible Dependents. Covered Dependents are also called Members.

Eligible Dependents Include:
- The Employee’s Spouse or same and opposite sex Domestic Partner. For information on spousal eligibility please contact the Employer.
- The Employee’s dependent children at the end of the month they attain age 26, legally adopted children from the date the Employee assumes legal responsibility, foster children that live with the Employee and for whom the Employee is the primary source of financial support, children for whom the Employee assumes legal guardianship and stepchildren. Also included are the Employee’s children (or children of the Employee’s Spouse) for whom the Employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the Employee for support, regardless of age, with the exception of incapacitated children age 26 or older. To be eligible for coverage as an incapacitated Dependent, the Dependent must have been covered under this Plan prior to reaching age 26. Certification of the disability is required within 31 days of attainment of age 28. A certification form is available from the Employer or from the Claims Administrator and may be required periodically.

Initial Enrollees
Initial Enrollees and eligible Dependents who were previously enrolled under group coverage which this Plan replaces are eligible for coverage on the Effective Date of this coverage. Coverage will be effective based on the waiting period chosen by the Employer, and will not exceed 90 days.

New Hires
Applications for enrollment must be submitted within 31 days from the date an Employee is eligible to enroll as set by the Employer. Applications for membership may be obtained from the Employer. Coverage will be effective based on the waiting period chosen by the Employer and will not exceed 90 days. If the Employee or the Employee’s Dependents do not enroll when first eligible, the Employee or the Employee’s Dependents will be treated as Late Enrollees. Please refer to the “Late Enrollees” provision listed below.

Late Enrollees
If the Employee or the Employee’s Dependents do not enroll when first eligible, it will be necessary to wait for the next open enrollment period. However, the Employee or the Employee’s Dependents may be eligible for special enrollment as set out below.

Special Enrollment Periods
If an Employee or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Employee or Dependent must request Special Enrollment within 31 days of a qualifying event.
Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact.
- Exhausted COBRA benefits or stopped receiving group contributions toward the cost of the prior health plan.
- Lost employer contributions towards the cost of the other coverage;
- Are now eligible for coverage due to marriage, birth, adoption, or placement for adoption.

Important Notes About Special Enrollment:

- Individuals enrolled during special enrollment periods are not Late Enrollees.
- Individuals or Dependents must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

Medicaid and CHIP Special Enrollment/Special Enrollees

Eligible Employees and Dependents may also enroll under two additional circumstances:

- the Employee’s or Dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- the Employee or Dependent becomes eligible for a subsidy (state premium assistance program).

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

When Coverage Begins

If the Employee applies for coverage when first eligible, coverage will be effective on the date the Employer’s length-of-service requirement has been met. The Effective Date of coverage is subject to any length-of-service provision the Employer requires and will not exceed 90 days.

Changing Coverage

There may be an annual re-enrollment period during which time Members may elect to change their options.

Types of Coverage

The types of coverage available to the Employee are indicated at the time of enrollment through the Employer.

Changing Coverage (Adding a Dependent)

You may add new Dependents to Your Plan by contacting Your Plan Administrator. The Plan Administrator must notify the Claims Administrator. The Plan Administrator is the person named by the Employer to manage the Plan and answer questions about Plan details.

Coverage is provided only for those Dependents the Employee has reported to the Plan Administrator and added to his or her coverage by completing the correct application.

Marriage and Stepchildren

An Employee may add a Spouse and eligible stepchildren within 31 days of the date of marriage by submitting a change-of-coverage form. The Effective Date will be the date of marriage.

If an Employee does not apply for coverage to add a Spouse and stepchildren within 31 days of the date of marriage, the Spouse and stepchildren are considered Late Enrollees. Please refer to the “Late Enrollees” provision in this section.
Newborn and Adopted Children
You must contact Your Employer within 31 days to add a newborn or adopted child.

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

OBRA 1993 and Qualified Medical Child Support Orders
The Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) provides specific rules for the coverage of adopted children and children subject to a Qualified Medical Child Support Order (QMCSO).

An eligible Dependent child includes:
• An adopted child, regardless of whether or not the adoption has become final.
• An “adopted child” is any person under the age of 18 as of the date of adoption or placement for adoption. “Placement for adoption” means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends.
• A child for whom an Employee has received an MCSO (a “Medical Child Support Order”) which has been determined by the Employer or Plan Administrator to be a Qualified Medical Child Support Order (“QMCSO”).
• Upon receipt of a QMCSO, the Employer or Plan Administrator will inform the Employee and each affected child of its receipt of the order and will explain the procedures for determining if the order is a QMCSO. The Employer will subsequently notify the Employee and the child(ren) of the determination.

A QMCSO cannot require the Employer to provide any type or form of benefit that it is not already offering.

Family and Medical Leave
If a covered Employee ceases active employment due to an Employer-approved medical leave of absence, in accordance with the Family and Medical Leave Act of 1993 (FMLA), coverage will be continued for up to 12 weeks under the same terms and conditions which would have applied had the Employee continued in active employment. The Employee must pay his or her contribution share toward the cost of coverage, if any contribution is required.

Changing Coverage or Removing a Dependent
When any of the following events occur, notify the Employer and ask for appropriate forms to complete:
• Divorce;
• Death of an enrolled family member (a different type of coverage may be necessary);
• Dependent child reaches age 26 (see “When Coverage Terminates”);
• Enrolled Dependent child becomes totally or permanently disabled.

Employee Not Actively at Work
Generally, if an Employee is not actively at work on the date his or her coverage is to be effective, the Effective Date will be postponed until the date the Employee returns to active status. If an Employee is not actively at work due to health status, this provision will not apply. An Employee is also a person still employed by the Employer but not currently active due to health status.
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
Your health 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 Customer Service to ask for a list of doctors and Providers that participate in this Plan’s Network, based on specialty and geographic area.
- Check with Your doctor or Provider.

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

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

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

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

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

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

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

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

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

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

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

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

Copayment
Certain Network services may be subject to a Copayment amount which is a flat-dollar amount You will be charged at the time services are rendered.

Copayments are the responsibility of the Member. Any Copayment amounts required are shown in the Schedule of Benefits. Unless otherwise indicated, services which are not specifically identified in this Benefit Booklet as being subject to a Copayment are subject to the calendar year Deductible and payable at the percentage payable in the Schedule of Benefits.

Calendar Year Deductible
Before the Plan begins to pay benefits (except certain benefits which are subject to Copayment instead of Deductible), You must meet any Deductible required. You must satisfy one Deductible for each type of coverage as explained in the Schedule of Benefits. Deductible requirements are stated in the Schedule of Benefits.
HEALTH CARE MANAGEMENT - PRECERTIFICATION

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

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

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

Types of Requests:

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

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

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

Failure to Obtain Precertification Penalty:

IMPORTANT NOTE: IF YOU OR YOUR NON-NETWORK PROVIDER DO NOT OBTAIN THE REQUIRED PRECERTIFICATION, A $300 PENALTY WILL APPLY AND YOUR OUT-OF-POCKET COSTS WILL INCREASE. THIS DOES NOT APPLY TO MEDICALLY NECESSARY SERVICES FROM A NETWORK OR BLUECARD PROVIDER.
The following list is not all inclusive and is subject to change; please call the Customer Service telephone number on Your Identification Card to confirm the most current list and requirements for Your Plan.

**Inpatient Admission:**
- All acute Inpatient, Skilled Nursing Facility, Long Term Acute Rehabilitation, and Obstetrical delivery stays beyond the 48/96 hour Federal mandate length of stay minimum (including newborn stays beyond the mother’s stay).
- Emergency Admissions (requires Plan notification no later than two business days after admission).

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

University of Cincinnati
Active Employee PPO Medical Plan
Package 006
Effective January 1, 2016
- Transtympanic Micropressure for the Treatment of Ménière’s Disease
- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Varicose Vein Treatment

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

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

**Mental Health/Substance Abuse (MHSA):**

**Precertification Required**
- Acute Inpatient Admissions
- Electric Convulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Care

**The following services do not require Precertification, but are recommended for pre-determination of Medical Necessity due to the existence of post service claim review criteria and/or the potential cost of services to the Member if denied by for lack of Medical Necessity:** Procedures, equipment, and/or specialty infusion drugs which have Medically Necessary criteria determined by the Claims Administrator’s Medical Policy or Clinical Guidelines.

Utilizing a Provider outside of the Network may result in significant additional financial responsibility for You, because Your health benefit 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?

<table>
<thead>
<tr>
<th>Services provided by a Network Provider, including BlueCard Providers in the service areas of Anthem Blue Cross and Blue Shield (CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI); Anthem Blue Cross (CA); Empire Blue Cross Blue Shield; Blue Cross Blue Shield of Georgia; and any future affiliated Blue Cross and/or Blue Shield plans resulting from a merger or acquisition by the Claims Administrator’s parent company.</th>
<th>Services provided by BlueCard providers outside the service areas of the states listed in the column to the left, BlueCard providers in other states not listed, and any Out-of-Network/Non-Participating Provider.</th>
</tr>
</thead>
</table>
| Provider is responsible for Precertification. | • Member is responsible for Precertification.  
• Member is financially responsible for service and/or setting that are not covered under this Plan based on an Adverse Determination of Medical Necessity or Experimental/Investigative. |

The Claims Administrator will utilize its clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines, and other applicable policies and procedures to assist in making Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. The Claims Administrator reserves the right to review and update these clinical coverage guidelines periodically. Your Employer’s Plan takes precedence over these guidelines.

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

The Claims Administrator may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in the Claims Administrator’s discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, the Claims Administrator may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. The Claims Administrator may also exempt Your claim from medical review if certain conditions apply.

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

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

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.
Request Categories:

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

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

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

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

**Decision and Notification Requirements**

Timeframes and requirements listed are based in general on federal regulations. You may call the telephone number on Your Membership Card for additional information.

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

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

The Claims Administrator will provide notification of its decision in accordance with federal regulations.

Notification may be given by the following methods:

- **Verbal**: oral notification given to the requesting provider via telephone or via electronic means if agreed to by the provider.
- **Written**: mailed letter or electronic means including email and fax given to, at a minimum, the requesting provider and the Member or authorized Member representative.
Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date You receive service:
1. You must be eligible for benefits;
2. the service or surgery must be a Covered Service under Your Plan; and
3. the service cannot be subject to an exclusion under Your Plan.
4. You must not have exceeded any applicable limits under Your Plan.

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

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

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

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

Payment terms apply to all Covered Services. Please refer to the Schedule of Benefits for details.

All Covered Services must be Medically Necessary, whether provided through Network Providers or Out-of-Network Providers.

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

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

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

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

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

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

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

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

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

Other non-covered ambulance services include, but are not limited to, trips to:
- A Doctor’s office or clinic;
- A morgue or funeral home.
Important Notes on Air Ambulance Benefits
Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger Your health and Your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

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

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

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/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 or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this Benefit Booklet.

Covered Services include the following:
- **Inpatient Services** in a Hospital or any Facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsie therapy, and detoxification.

- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
  - Observation and assessment by a psychiatrist weekly or more often,
  - Rehabilitation, therapy, and education.

Examples of Providers from whom You can receive Covered Services include:
- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when they have to be covered by law.

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

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

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

Benefits are limited to the following trials:

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

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

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

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

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

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.
Your Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services

i. The 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.

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
Your 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 Member’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
Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Member meets any of the following conditions:
• The Member is under the age of five (5);
• The Member has a severe disability that requires hospitalization or general anesthesia for dental care; or
• The Member 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 Member 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 Member’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 Member’s physical disorder.

Emergency Services

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

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

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

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

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

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:
- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.
Habilitative Services
Benefits also include habilitative health care services and devices that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or outpatient settings.

Home Health Care Services
Home Health Care provides a program for the Member’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 Member’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 Member 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 Member.
• 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 Member to understand the emotional, social, and environmental factors resulting from or affecting the Member’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 Member’s home or is a member of the family of either the Member or Member’s Spouse.
• Any services for any period during which the Member is not under the continuing care of a Physician.
• Convalescent or Custodial Care where the Member 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 Member.
• 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.

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 Member 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 customer service telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Member 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 Member.

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

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

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

**Transportation and Lodging**
The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Member and one companion for an adult Member, or two companions for a child patient. The Member 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 benefit stated in the **Schedule of Benefits**. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and
ded % 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 Member’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 Member 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
Member’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 Member’s attending Physician.

**Abortion (Therapeutic)** - Your 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.

**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.

**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.

**Out-of-Network Freestanding Ambulatory Facility**
Any services rendered or supplies provided while You are a patient or receiving services at or from a
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” section.

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

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. You Services include, but are not limited to communications used for:
- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification;
- Physician to Physician consultation.

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

Outpatient Hospital Services
The Plan provides Covered Services when the following Outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

Outpatient Surgery
Network Hospital Outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under “Hospital Services”.

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

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

Preventive Care
Preventive care services include screenings and other services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

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

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

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

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

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

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
a. Women's contraceptives, sterilization procedures, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered as Preventive Care benefit when Medically Necessary, otherwise they will be covered under the Prescription Drug benefit.

b. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

c. Gestational diabetes screening.

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

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

6. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
   a. aspirin;
   b. folic acid supplement;
   c. vitamin D supplement;
   d. iron supplement; and
   e. bowel preparations.

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

You may call Customer Service 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](http://www.healthcare.gov/center/regulations/prevention.html), [http://www.ahrq.gov](http://www.ahrq.gov), and [http://www.cdc.gov/vaccines/acip/index.html](http://www.cdc.gov/vaccines/acip/index.html).

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

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

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth, except to correct traumatic Injuries; electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.
Reconstructive Surgery
Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

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

Retail Health Clinic
Benefits are provided for Covered Services received at a Retail Health Clinic.

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 Member’s residence.

Covered Services include:
- semiprivate or ward room charges including general nursing service, meals, and special diets. If a 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 Member reaches the maximum level of recovery possible and no longer requires other than routine care;
- Care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- Care is for mental illness including drug addiction, chronic brain syndromes and alcoholism, and no specific medical conditions exist that require care in a Skilled Nursing Facility;
- A Member is undergoing senile deterioration, mental deficiency or retardation, and has no medical condition requiring care;
- The care rendered is for other than Skilled Convalescent Care.

Surgical Care
Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.
Treatment of Accidental Injury in a Physician’s Office
All Outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician’s office, will be covered under the Member’s Physician’s office benefit if services are rendered by a Network Provider; services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

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

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

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

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

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

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

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

As described in the “Prescription Drugs Administered by a Medical Provider” section, Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include prior authorization, step therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Network Pharmacist will be told of any rules when You fill a Prescription, and will be also told about any details the Claims Administrator needs to decide benefits.

If Prior Authorization is denied, You have the right to appeal through the appeals process outlined in the "Right to Appeal" provision of this Benefit Booklet. (The provision appears in the “Claims and General Information” section.)
For a list of the current Drugs requiring Prior Authorization, please contact the Customer Service telephone number on Your Identification card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage. Refer to the Prescription Drug benefit sections in this Benefit Booklet for information on coverage, limitations, and exclusions. Your Provider or Network Pharmacist may check with the Claims Administrator to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Plan.

**Specialty Pharmacy Network**
The PBM’s Specialty Pharmacy Network is available to Members who use Specialty Drugs.

“Specialty Drugs” are Prescription Legend Drugs which:
- Are only approved to treat limited patient populations, indications, or conditions;
- Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

You may obtain the list of Network Specialty Pharmacies and covered Specialty Drugs by calling the Customer Service telephone number on Your Identification Card or review the lists on the Claims Administrator’s website at www.anthem.com.

**Covered Prescription Drug Benefits**
- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs are covered when obtained through an eligible Pharmacy. Certain contraceptives are covered under the “Preventive Care” benefit. Please see that section for further details.
- Certain supplies and equipment obtained by Home Delivery (Mail Service) or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment. Contact the Plan to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Home Delivery (Mail Service) or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the “Error! Reference source not found.” benefit.
- Flu Shots (including administration). These products will be covered under the “Preventive Care” benefit.
- Immunizations required by the “Preventive Care” benefit.
- Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. Benefits include FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These services will be covered under the “Preventive Care” benefit. Please see that section for further details.
- Compound Drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved and require a Prescription to dispense, and are not essentially the same as an FDA approved product from a Drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- Certain Prescription Legend drugs may be Covered Services if an over the counter equivalent exists. This list is subject to change on a semiannual basis. Please contact the Claims Administrator for the most current listing of medications.
You Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other You Services)

- Prescription Drugs dispensed by any Home Delivery (Mail Service) program other than the PBM’s Home Delivery (Mail Service), unless prohibited by law.
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This Exclusion does not apply to over-the-counter products that the Plan must cover under federal law with a Prescription.
- Off label use, except as otherwise prohibited by law or as approved by the Plan or the PBM.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA
- Charges for the administration of any Drug.
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including, but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- Any Drug which is primarily for weight loss.
- Drugs not requiring a Prescription by federal law (including Drugs requiring a Prescription by state law, but not by federal law), except for injectable insulin.
- Drugs in quantities, which exceed the limits established by the Plan, or which exceed any age limits established by the Plan.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs.
- Oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices, or products, they are not Covered Services.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Compound Drugs unless all of the ingredients are FDA-approved and require a Prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a Drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter. Please contact the Plan for additional information on these Drugs.
- Certain Prescription Drugs may not be covered when clinically equivalent alternatives are available, unless otherwise required by law. “Clinically equivalent” means Drugs that, for the majority of Members, can be expected to produce similar therapeutic outcomes for a disease or condition. If You have questions regarding whether a particular drug is covered and which drugs fall into this category, please call the member services number on Your Identification Card, or visit the Claims Administrator’s website at www.anthem.com.

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

Days Supply
The number of days supply of a Drug, which You may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits.
Formulary
The Plan follows a drug Formulary in determining payment and Covered Services. You will be responsible for an additional Copayment amount depending on whether a Formulary or non-Formulary drug is obtained. Please see the Schedule of Benefits.

Tiers
Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- **Tier 1** drugs have the lowest Copayment. This tier will contain low cost or preferred medications. This tier may include generic, single source brand drugs, or multi-source brand drugs.

- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.

- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.

- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3.

Drugs are assigned to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. The Plan decides coverage for doses and administration (i.e., oral, injection, topical, or inhaled). The Plan may cover one form of administration instead of another, or put other forms of administration in a different tier.

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

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

The Claims Administrator retains the right at the Claims Administrator’s discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

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

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

For Covered Services provided by an Out-of-Network Pharmacy, You will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowed Amount.
How to Obtain Prescription Drug Benefits

How You obtain Your benefits depends upon whether You go to a Network or an Out-of-Network Pharmacy.

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

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

Specialty Drugs - You or Your Physician can order Your Specialty Drugs directly from a Specialty Network Pharmacy, simply call the Customer Service telephone number on the back of Your ID Card. If You or Your Physician orders Your Specialty Drugs from a Specialty Network Pharmacy, You will be assigned a patient care coordinator who will work with You and Your Physician to obtain Prior Authorization and to coordinate the shipping of Your Specialty Drugs directly to You or Your Physician’s office. Your patient care coordinator will also contact You directly when it is time to refill Your Specialty Drug Prescription.

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

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

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

The Home Delivery (Mail Service) Program – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written Prescriptions from Your Physician, or have Your Physician fax the Prescription to the PBM’s Home Delivery (Mail Service). Your Physician may also phone in the Prescription to the PBM’s Home Delivery (Mail Service) Pharmacy. You will need to submit the applicable Copayment amounts to the PBM’s Home Delivery (Mail Service) when You request a Prescription or refill.
LIMITATIONS AND EXCLUSIONS

1. Abortions - For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Benefits" section. Elective medical or surgical abortion, unless:
   a. The pregnancy would endanger the life of the mother; or
   b. The pregnancy is a result of rape or incest; or
   c. The fetus has been diagnosed with a lethal or otherwise significant abnormality.

2. 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.

3. 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 Member, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

4. 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.

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

6. Before Coverage Begins / After Coverage Ends - Services rendered or supplies provided before coverage begins, i.e., before a Member's Effective Date, or after coverage ends.

7. Biomicroscopy - Biomicroscopy, field charting or aniseikonic investigation.

8. Certain Providers - Service You get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet. Examples of non-covered providers include, but are not limited to, masseurs or masseuses (massage therapists), and physical therapist technicians.

9. 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.

10. Complications - Complications of non-covered procedures are not covered.

11. Cosmetic Services / Beautification Procedures - Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery. This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty and services for the correction of asymmetry, except when determined to be Medically Necessary by the Claims Administrator is not covered. (See sections a. and b. below.)
a. This exclusion does not apply to surgery to restore function if any bodily area has been altered by
disease, trauma, congenital/developmental anomalies, or previous therapeutic processes. This
exclusion does not apply to surgery to correct the results of injuries that caused the impairment,
or as a continuation of a staged reconstruction procedure, or congenital defects necessary to
restore normal bodily functions, including but not limited to, cleft lip and cleft palate.

b. This exclusion does not apply to Breast Reconstructive Surgery.

Complications directly related to cosmetic services treatment or surgery, as determined by the Claims
Administrator, are not covered. This exclusion applies even if the original cosmetic services
treatment or surgery was performed while the Member was covered by another carrier / self-funded
plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred
as a direct result of the cosmetic services treatment or surgery and would not have taken place in the
absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions
including, but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and
exacerbation of co-morbid conditions.

12. 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.

13. 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 Your involvement in the crime was solely the result of
a medical or mental condition, or where You were the victim of a crime, including domestic violence.

14. 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.

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

16. 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.

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

18. Excessive Expenses - Expenses in excess of the Plan’s Maximum Allowed Amount.

19. 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.
20. **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 Member is being treated. An Experimental or Investigative service is not made eligible for coverage by the fact that other treatment is considered by a Member'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.

21. **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.

22. **Foot Care** - Foot care only to improve comfort or appearance, routine care of corns, calluses, toenails (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 Members with impaired circulation to the lower extremities.

23. **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.

24. **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 Member 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.

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

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

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

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

29. **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.

30. **Inpatient Rehabilitation Programs** - Inpatient rehabilitation in the Hospital or Hospital-based rehabilitation facility, when the Member 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 Member 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.

31. **International Services** - Non-emergency treatment of chronic illnesses received outside the United States performed without preauthorization. See the information on the BlueCard Worldwide program in this Benefit Booklet for further details.

32. **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.

33. **Marital Counseling** - Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.
34. **Medicare Benefits** - Services paid under Medicare or which would have been paid if the Member 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 Member has enrolled Medicare Part B. For services provided pursuant to a private contract between the Member 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.

35. **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.

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

37. **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.

38. **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. Any services or supplies that involve weight reduction as the main method of treatment, including medical, or counseling. Weight loss programs included but are not limited to, commercial weight loss programs (Weight Watcher, Jenny Craig, and LA Weight Loss), nutritional supplements, appetite suppressants, and supplies of a similar nature. Excluded procedures include, but are not limited to, specific bariatric services and surgeries (e.g., liposuction, gastric balloons, jejunal bypasses, and wiring of the jaw).

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

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

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

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

43. **Research Screenings** – For examinations related to research screenings, unless required by law.
44. **Reversal of Sterilization** - Services related to or performed in conjunction with reverse sterilization.

45. **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.

46. **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.

47. **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.

48. **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.

49. **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 protheses 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.

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

51. **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).

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

53. **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 Member’s house or place of business and adjustments made to vehicles;
   f. Air conditioners, humidifiers, dehumidifiers, or purifiers;
   g. Rental or purchase of equipment if You are in a facility which provides such equipment;
   h. Other items of equipment that the Claims Administrator determines do not meet the listed criteria.

54. **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.

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University of Cincinnati
Active Employee PPO Medical Plan
Package 006
Effective January 1, 2016
55. **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;

56. **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.

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

58. **Thermograms** - Thermograms and thermography.

59. **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.

60. **Vision Surgeries** - Related to radial keratotomy or keratomeileusis 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.

61. **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.

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

63. **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.

64. **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 Member. 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 Your local Human Resources Department 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 Your Employer 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 this Plan’s Maximum Allowed Amount for the Covered Service that You receive. Please see the Inter-Plan Programs section for additional information.

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

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your 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 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 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 this Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or visit www.anthem.com.

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

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

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

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers’ fees and costs to deliver care; or

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

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

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

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

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

**For Prescription Drugs:** The Maximum Allowed Amount is the amount determined by the Claims Administrator using Prescription Drug cost information provided by the Pharmacy Benefits Manager (PBM).

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

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

The Plan will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by a Network or 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.

University of Cincinnati
Active Employee PPO Medical Plan
Package 006
Effective January 1, 2016
In some instances You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider’s charge.

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

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

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

Timeliness of Filing for Member 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 Member, 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.

Claims Review
The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider’s failure to submit medical records with the claims that are under review in these processes.
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 and for ERISA plans, information regarding the right to bring an action after the Appeals process.

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

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

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

Whenever You access covered healthcare services outside Anthem’s service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:
- The billed covered charges for Your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

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

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

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

Non-Participating Healthcare Providers Outside Anthem’s Service Area

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

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

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

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

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

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

The coverage and any benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above.
Questions About Coverage or Claims
If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator’s Customer Service Department. Be sure to always give Your Member Identification number.

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

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

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

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

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

The Administrator’s Member Services representatives are trained to answer Your questions about Your health benefit plan. Please call during business hours, Monday through Friday, with questions regarding:

- Your coverage and benefit levels, including Coinsurance and Copayment amounts,
- Specific claims or services You have received,
- Doctors or Hospitals in the Network,
- Referral processes or authorizations,
- Provider directories.

Complaint and Appeal procedures have been established to provide fair, reasonable, and timely solutions to complaints that You may have concerning the Plan. The Plan invites You to share any concerns that You may have over benefit determinations, coverage and eligibility issues, or the quality of care rendered by medical Providers in the Administrator's Networks.

The Complaint Procedure
The Plan wants Your experience to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. In those cases, please contact Member Services by calling the number on the back of Your ID Card. The Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim.

Please refer to Your Identification Card for the Administrator's address and telephone number.

A complaint is an expression of dissatisfaction that can often be resolved by an explanation from the Administrator of its' procedures and Your benefit document. You may submit Your complaint by letter or by telephone call. If Your complaint involves issues of Covered Services, You may be asked to sign a release of information form so the Administrator can request records for its' review.

You will be notified of the resolution of Your complaint if a claim or request for benefits is denied in whole or in part. The Administrator will explain why benefits were denied and describe Your rights under the Appeal Procedure. If You are not satisfied with the resolution of Your complaint, You have the right to file an Appeal, which is defined as follows:

Appeal Procedures
As a Member of this Plan You have the right to appeal decisions to deny or limit Your health care benefits. The explanation of why the Plan denied Your claim or request for benefits will describe the steps You should follow to initiate Your appeal and how the appeal process works.

An appeal is a request from You for the Administrator to change a previous determination or to address a concern You have regarding confidentiality or privacy.

Internal Appeals
An initial determination by the Administrator can be appealed for internal review. The Plan will advise You of Your rights to appeal to the next level if a denial occurs after an initial determination.

You have the right to designate a representative (e.g. Your Physician) to file appeals with the Administrator on Your behalf and to represent You in any level of the appeals process. If a representative is seeking an appeal on Your behalf, the Administrator must obtain a signed Designation of Representation (DOR) form from You. The appeal process will not begin until the Administrator has received the properly completed DOR form except that if a Physician requests expedited review of an appeal on Your behalf, the Physician will be deemed to be Your designee for the limited purpose of filing for expedited review of the appeal without receipt of a signed form. The Administrator will forward a Designation of Representation form to You for completion in all other situations.
The Administrator will accept oral or written comments, documents or other information relating to an appeal from the Member or the Member’s Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Member’s appeal. If, after the Administrator’s determination that You are appealing, the Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Administrator will provide You with that new or additional evidence, free of charge. The Administrator will not base its appeal(s) decision(s) 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 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 our control.

To obtain information on the Administrator's appeal procedures or to file an oral appeal please call the toll free Member Services number listed on the back of Your Plan Identification Card or the number provided for appeals on any written notice of an adverse decision that You receive from the Administrator.

The Administrator will also accept appeals filed in writing. If You wish to file Your appeal in writing, You must mail it to: Anthem Blue Cross and Blue Shield, P.O. Box 105568, Atlanta, GA 30348, or to the address provided for filing an appeal on any written notice of an adverse decision that You receive from the Administrator.

Appeals are reviewed by persons who did not make the initial determination and who are not the subordinates of the initial reviewer. If a clinical issue is involved, the Administrator will use a clinical peer for this review. A clinical peer is a Physician or Provider who has the same license as the Provider who will perform or has performed the service. The clinical peer will review Your medical records and determine if the service is covered by Your benefit document. If the clinical peer determines that the service is covered by Your benefit document the Plan must pay for the service; if the clinical peer determines that the service is not covered the Plan may deny the services.

Standard Appeals
If You are appealing an adverse precertification decision other than a retrospective post-claim review decision (i.e., an adverse prospective, concurrent or retrospective pre-claim review decision) or the denial of any prior approval required by the Plan, the Administrator will provide You with a written response indicating the Administrator’s decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days of the date the Administrator receives Your appeal request. If more information is needed to make a decision on Your Appeal, the Administrator will send a written request for the information after receipt of the Appeal. No extensions of time for additional information may be taken on these Appeals without the permission of the Member. Therefore, the Administrator will make a decision based upon the available information if the additional information requested is not received.

If You are appealing any other type of adverse decision (including retrospective post-claim review decisions) and sufficient information is available to decide the Appeal, the Administrator will provide You with a written response indicating its’ decision within a reasonable period of time appropriate to the medical circumstances but not later than 30 calendar days from receipt of the Appeal request. If more information is needed to make a decision on Your Appeal, the Administrator shall send a written request for the information after receipt of the Appeal. If the additional information requested is not received within 45 calendar days of the Appeal request, the Administrator shall conduct its review based upon the available information.
**Expedited Appeals**

An expedited appeal may be initiated orally, in writing, or by other reasonable means available to You or Your Provider. Given the urgent nature of an expedited appeal, You are encouraged to request an expedited appeal orally. An expedited appeal is available only if the medical care for which coverage is being denied has not yet been rendered. The Administrator will complete expedited review of an appeal as soon as possible given the medical exigencies but no later than seventy-two hours (72 hours) after the Administrator’s receipt of the request and will communicate the Administrator’s decision by telephone to Your attending Physician or the ordering Provider. The Administrator will also provide written notice of the Administrator’s determination to You, Your attending Physician or ordering Provider, and the facility rendering the service.

You may request an expedited review for:
- Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:
  1. Could seriously jeopardize Your life or health or Your ability to regain maximum function, or,
  2. In the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;
- Except as provided above, a claim involving urgent care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine;
- Any claim that a Physician with knowledge of Your medical condition determines is a claim involving urgent care.

**Exhaustion of Internal Appeals Process**

The internal appeal process must be exhausted prior to initiating an external review except in the following instances:
- The Administrator agrees to waive the exhaustion requirement; or
- You did not receive a written decision of the Administrator’s internal appeal within the required time frame; or
- The Administrator failed to meet all requirements of the internal appeal process unless the failure:
  1. Was de minimis (minor);
  2. Does not cause or is not likely to cause prejudice or harm to You;
  3. Was for good cause and beyond the Administrator’s control;
  4. Is not reflective of a pattern or practice of non-compliance; or
- An expedited external review is sought simultaneously with an expedited internal review.

**External Review**

Definitions as used in the External Review section include the following:

"**Adverse benefit determination**" means a decision by a health plan issuer:
- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
  - A determination that the health care service does not meet the health plan issuer’s requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
  - A determination of an individual’s eligibility for individual health insurance coverage, including coverage offered to individuals through a non employer group, to participate in a plan or health insurance coverage;
  - A determination that a health care service is not a covered benefit;
  - The imposition of an exclusion, including exclusions source of injury, network, or any other limitation on benefits that would otherwise be covered.
• Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
• To rescind coverage on a health benefit plan.

“Authorized representative” means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

• A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
• A person authorized by law to provide substituted consent for a covered individual;
• A family member or a treating health care professional, but only when the covered person is unable to provide consent.

“Covered person” means a subscriber, enrollee, member, or individual covered by a health benefit plan. “Covered person” does include the covered person’s authorized representative with regard to an internal appeal or external review.

“Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.

“Final adverse benefit determination” means an adverse benefit determination that is upheld at the completion of a health plan issuer’s internal appeals process.

“Health benefit plan” means a benefit plan offered by an Employer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

“Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

“Health plan issuer” means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. “Health plan issuer” includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent. The “Health plan issuer” is also called the Administrator in this Benefit Booklet.

“Independent review organization” means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.

“Rescission” or “to rescind” means a cancellation or discontinuance of coverage that has a retroactive effect. “Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

“Stabilize” means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:
• Placing the health of the covered 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;
  – Serious dysfunction of any bodily organ or part.
• In the case of a woman having contractions, “stabilize” means such medical treatment as may be necessary to deliver, including the placenta.

“Superintendent” means the superintendent of insurance.

Understanding the External Review Process
Under Chapter 3922 of the Ohio Revised Code all health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. This is a summary of that external review process. An adverse benefit determination is a decision by the Plan to deny benefits because services are not covered, are excluded, or limited under the plan, or the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review
An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer’s internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

External Review by an IRO - A covered person is entitled to an external review by an IRO in the following instances:
• The adverse benefit determination involves a medical judgment or is based on any medical information.
• The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person’s health benefit plan, and the treating physician certifies at least one of the following:
  – Standard health care services have not been effective in improving the condition of the covered person.
  – Standard health care services are not medically appropriate for the covered person.
  – No available standard health care service covered by the Plan is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

• The covered person’s treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.

• The covered person’s treating physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
• The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.

• An expedited internal appeal is already in progress for an adverse benefit determination of experimental or investigational treatment and the covered person’s treating physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

Note: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person).

External Review by the Ohio Department of Insurance - A covered person is entitled to an external review by the Department in the either of the following instances:

• The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or medical information.

• The adverse benefit determination for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND the Administrator's decision has already been upheld through an external review by an IRO.

Request for External Review
Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through the Administrator within 180 days of the date of the notice of final adverse benefit determination issued by the Administrator. All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally; however, written confirmation of the request must be submitted to the Administrator no later than five (5) days after the initial request. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete the Administrator will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. The Administrator will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete the Administrator will inform the covered person in writing and specify what information is needed to make the request complete. If the Administrator determines that the adverse benefit determination is not eligible for external review, the Administrator must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by the Administrator and require that the request be referred for external review. The Department’s decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.
IRO Assignment
When the Administrator initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with the Administrator, the covered person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision
The IRO must consider all documents and information considered by the Administrator in making the adverse benefit determination, any information submitted by the covered person and other information such as; the covered person’s medical records, the attending health care professional’s recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO’s clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by the Administrator of a request for a standard review or within 72 hours of receipt by the Administrator of a request for an expedited review. This notice will be sent to the covered person, the Administrator and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

Note: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO’s decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision
An external review decision is binding on the Plan except to the extent the Administrator has other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law. A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to the Administrator.

If You Have Questions About Your Rights or Need Assistance
You may contact the Administrator:

Anthem Blue Cross and Blue Shield
P.O. Box 105568, Atlanta, GA 30348

To contact the Administrator by phone please call the number on back of Your Identification Card
Fax: 1-888-859-3046
E-Mail: Ohio.Appeals@anthem.com
You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300, Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)
Contact ODI Consumer Affairs:
https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp

File a Consumer Complaint:
http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx

**Appeal Filing Time Limit**
The Plan expects that You will use good faith to file an appeal on a timely basis. However, the Administrator will not review an appeal if it is received after 180 days have passed since the incident leading to Your appeal.
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 Allowable Amount.

COB Definitions

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

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

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

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

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

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

When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan’s benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.
**Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering You. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering You is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging You is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non-Allowable expenses:

1. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If You are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If You are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the negotiated fees is not an Allowable expense.
4. If You are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and 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 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.
6. Any amounts incurred or claims made under the Prescription Drug program of this Plan.

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

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

**Order Of Benefit Determination Rules**

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

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

1. Except as provided in Paragraph 2. below, a Plan that does not contain a Coordination of Benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.
A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

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

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

**Rule 2 - Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:
1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   - the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - if both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
   - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
   - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
     - The Plan covering the Custodial parent;
     - The Plan covering the Spouse of the Custodial parent;
     - The Plan covering the non-custodial parent; and then
     - The Plan covering the Spouse of the non-custodial parent.
3. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

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

**Rule 4 - COBRA.** 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, member, subscriber or retiree or covering You as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or 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, member, 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, member or subscriber or retired employee and is covered under the other plan as a Dependent of an employee, member, subscriber or retiree).

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

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

Effect On The Benefits Of This Plan
When a Member 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 Member.
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:

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

Determining the Allowable Expense When This Plan is Secondary to Medicare

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

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

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

Recovery

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

Subrogation

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

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

Reimbursement

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

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

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

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

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

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

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

Entire Agreement
This Benefit Booklet, the Administrative Services Agreement, the Employer’s application, any Riders, Endorsements or attachments, and the individual applications of the Subscribers and Members, if any, constitute the entire agreement between the Claims Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Claims Administrator by the Employer, and any and all statements made to the Employer 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 Employer.

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 Employer, including but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the 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
The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer’s Group Health Plan has a responsibility under the HIPAA Privacy Regulations to provide You with a Notice of Privacy Practices. This notice sets forth the Employer’s rules regarding the disclosure of Your information and details about a number of individual rights You have under the Privacy Regulations. As the Claims Administrator of Your Employer’s Plan, Anthem has also adopted a number of privacy practices and has described those in its Privacy Notice. If You would like a copy of Anthem’s Notice, contact the customer service number on Your Identification Card.

Workers’ Compensation
The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Workers’ Compensation Law. All sums paid or payable by Workers’ Compensation for services provided to a Member shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under 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 Members are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.
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 Member has not enrolled in Medicare Part B, the Plan will calculate benefits as if they had enrolled.

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

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

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

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

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

Relationship of Parties (Employer-Member-Claims Administrator)
Neither the Employer nor any Member is the agent or representative of the Claims Administrator.

The Employer is fiduciary agent of the Member. The Claims Administrator’s notice to the Employer will constitute effective notice to the Member. It is the Employer’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 Members if the Employer fails to provide the Claims Administrator with timely notification of Member enrollments or terminations.
Relationship of Parties (Claims Administrator - Network Providers)
The relationship between the Claims Administrator and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Claims Administrator, nor is the Claims Administrator, or any employee of the Claims Administrator, an employee or agent of Network Providers.

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

Community Insurance Company Note
The Employer, on behalf of itself and its Members, hereby expressly acknowledges its understanding that the Administrative Services Agreement (which includes this Benefit Booklet) constitutes a contract solely between the Employer and Community Insurance Company (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Ohio. 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 Employer at its principal place of business; to You at the Subscriber's address as it appears on the records or in care of the Employer.

Modifications or Changes in Coverage
The Plan Sponsor may change the benefits described in this Benefit Booklet and the Member 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 Employer, or by mutual agreement between the Claims Administrator and the Employer without the consent or concurrence of any Member. By electing medical and Hospital benefits under the Plan or accepting the Plan benefits, all Members legally capable of contracting, and the legal representatives of all Members 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 Member’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 Employer, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue benefits otherwise validly terminated.

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

Under the terms of the Administrative Service Agreement with Your Employer, 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 Members under the Plan. These programs will not result in the payment of benefits which are not provided in the Employer's Group Health Plan, unless otherwise agreed to by the Employer. The Claim's Administrator reserves the right to discontinue a pilot initiative at any time without advance notice to Employer.

Value-Added Programs
The Claims Administrator may offer health or fitness related programs to Members, through which You may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under Your Employer's Group health 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 Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Employer's Sole Discretion
The Employer may, in its sole discretion, cover services and supplies not specifically covered by the Plan. This applies if the Employer, with advice from the Claims Administrator, determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

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 Member Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation of the Benefit Booklet of the Plan. A specific limitation or exclusion will override more general benefit language. 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 Member may utilize all applicable Appeals procedures.
Governmental Health Care Programs
Under federal law, for groups with 20 or more Employees, all active Employees (regardless of age) can remain on the Group’s Health Plan and receive group benefits as primary coverage. Also, Spouses (regardless of age) of active Employees can remain on the Group’s Health Plan and receive group benefits as primary coverage. Direct any questions about Medicare eligibility and enrollment to Your local Social Security Administration office.

Medical Policy and Technology Assessment
The Claims Administrator reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of the Claims Administrator’s medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including the Claims Administrator’s medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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

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

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

Termination of Coverage (Individual)
Membership for You and Your enrolled family members may be continued as long as You are employed by the Employer and meet eligibility requirements. It ceases if Your employment ends, if You no longer meet eligibility requirements, if the Plan ceases, or if You fail to make any required contribution toward the cost of Your coverage. In any case, Your coverage would end at the expiration of the period covered by Your last contribution.

Coverage of an enrolled child ceases at the end of the month when the child attains the age limit shown in the Eligibility section. Coverage of a disabled child over age 28 ceases if the child is found to be no longer totally or permanently disabled.

Coverage of the Spouse of a Subscriber terminates automatically as of the date of divorce or death.

Should You or any family Members be receiving covered care in the Hospital at the time Your membership terminates for reasons other than Your Employer’s cancellation of this Plan, or failure to pay the required Premiums, benefits for Hospital Inpatient care will be provided until the date You are discharged from the Hospital.

Continuation of Coverage (Federal Law-COBRA)
If Your coverage ends under the Plan, You may be entitled to elect continuation coverage in accordance with federal law. If Your employer normally employs 20 or more people, and Your employment is terminated for any reason other than gross misconduct You may elect from 18-36 months of continuation benefits. You should contact Your Employer 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 group 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.” You, Your Spouse and Your Dependent children could become qualified beneficiaries if covered on the day before the qualifying event and group coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each member of Your family who is enrolled in the company’s employee welfare benefit plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their Spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

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<thead>
<tr>
<th>Initial Qualifying Event</th>
<th>Length of Availability of Coverage</th>
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<tbody>
<tr>
<td><strong>For Employees:</strong> Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer’s Health Plan Due to Reduction In Hours Worked</td>
<td>18 months</td>
</tr>
<tr>
<td><strong>For Spouses/ Dependents:</strong> 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</td>
<td>18 months</td>
</tr>
</tbody>
</table>

University of Cincinnati
Active Employee PPO Medical Plan
Package 006
Effective January 1, 2016
<table>
<thead>
<tr>
<th>Initial Qualifying Event</th>
<th>Length of Availability of Coverage</th>
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</thead>
<tbody>
<tr>
<td>Covered Employee’s Entitlement to Medicare</td>
<td>36 months</td>
</tr>
<tr>
<td>Divorce or Legal Separation</td>
<td>36 months</td>
</tr>
<tr>
<td>Death of a Covered Employee</td>
<td>36 months</td>
</tr>
<tr>
<td><strong>For Dependents:</strong></td>
<td></td>
</tr>
<tr>
<td>Loss of Dependent Child Status</td>
<td>36 months</td>
</tr>
</tbody>
</table>

Continuation coverage stops before the end of the maximum continuation period if the Member 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 children can last up to 36 months after the date of Medicare entitlement.)

If You are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage, You will become a qualified beneficiary with respect to the bankruptcy. Your surviving Spouse and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life. His or her Spouse and Dependents may continue coverage for a maximum period of up to 36 months following the date of the retiree’s death.

**Second qualifying event**
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, Your Employer must notify the company’s benefit Plan Administrator within 30 days. You must notify the company’s benefit Plan Administrator within 60 days of Your divorce, legal separation or the failure of Your enrolled Dependents to meet the program’s definition of Dependent. This notice must be provided in writing to the Plan Administrator. Thereafter, the Plan Administrator will notify qualified beneficiaries of their rights 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 company’s benefit 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 active associates, Your monthly Premium will also change. The Premium You must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company’s benefit 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 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 Employees who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These 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 Employer can charge 150% of 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.)

Trade Adjustment Act Eligible Individual
If You don’t initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused You to be eligible initially for COBRA coverage under this Plan, You will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which You become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period. You may also be eligible to receive a tax credit equal to 72.5% of the cost for health coverage for You and Your Dependents charged by the Plan. This tax credit also may be paid in advance directly to the health coverage provider, reducing the amount You have to pay out of pocket.

When COBRA Coverage Ends
These benefits are available without proof of insurability and coverage will end on the earliest of the following:
- a covered individual reaches the end of the maximum coverage period;
- a covered individual fails to pay a required Premium on time;
- a covered individual becomes covered under any other group health plan after electing COBRA;
- a covered individual becomes entitled to Medicare after electing COBRA; or
- the Group terminates all of its group welfare benefit plans.

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

If You Have Questions
Questions concerning Your Group’s health Plan and Your COBRA continuation coverage rights should be addressed to the Employer. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Continuation of Coverage During Military Leave (USERRA)
Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Member may have a right to continuation of benefits subject to the conditions described below.

Under USERRA, if the Employee (or his or her Dependents) is covered under this Plan, and if the Employee becomes absent from employment by reason of military leave, the 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 Employee is gone on military leave, the Employee must give reasonable notice to the Employer of his or her military leave and the Employee will be entitled to
COBRA-like rights with respect to his or her medical benefits in that the 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 Employee to apply for or return to work with the Employer. During military leave the Employee is required to pay the Employer for the entire cost of such coverage, including any elected Dependents’ coverage. However, if the Employee’s absence is less than 31 days, the employer must continue to pay its portion of the Premiums and the Employee is only required to pay his or her share of the Premiums without the COBRA-type 2% administrative surcharge.

Also, when the Employee returns to work, if the Employee meets the requirements specified below, USERRA states that the Employer must waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation. These requirements are (i) the Employee gave reasonable notice to his or her Employer of military leave, (ii) the military leave cannot exceed a prescribed period (which is generally five (5) years, except in unusual or extraordinary circumstances) and the 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 Employee must apply for reemployment or return to work in a timely manner upon expiration of the military leave (ranging from a single day up to 90 days, depending upon the period that he or she was gone). The Employee may also have to provide documentation to the Employer upon reemployment that would confirm eligibility. This protection applies to the Employee upon reemployment, as well as to any Dependent who has become covered under the Plan by reason of the Employee’s reinstatement of coverage.

**Continuation of Coverage Due to Family and Medical Leave (FMLA)**
An employee may continue membership in the Plan as provided by the Family and Medical Leave Act. An employee who has been employed at least one year, within the previous 12 months is eligible to choose to continue coverage for up to 12 weeks of unpaid leave for the following reasons:

- The birth of the employee’s child.
- The placement of a child with the 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 employee unable to perform his or her job.

If the employee chooses to continue coverage during the leave, the employee will be given the same health care benefits that would have been provided if the employee were working, with the same premium contribution ratio. If the employee’s premium for continued membership in the Plan is more than 30 days late, the Employer will send written notice to the employee. It will tell the employee that his or her membership 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 membership in the Plan is discontinued for non-payment of premium, the employee’s coverage will be restored to the same level of benefits as those the employee would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible dependents. The 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.

Please contact Your Human Resources Department for state specific Family and Medical Leave Act information.

**For More Information**
This notice does not fully describe the continuation coverage or other rights under the Plan. More information about continuation coverage and Your rights under this Plan is available from the Plan Administrator.

If You have any questions concerning the information in this notice or Your rights to coverage, You should contact Your Employer.
For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S Department of Labor's Employee Benefits Security Administration (EBSA) in Your area, or visit the EBSA website at www.dol.gov/ebsa.
DEFINITIONS

Accidental Injury
Bodily Injury sustained by a Member 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 Member 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 Employer regarding the administration of certain elements of the health care benefits of the Employer's Group Health 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 Member may be responsible for the difference between the Out-of-Network Provider’s charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the “Claims Payment” section.

Behavioral Health Care
Includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Benefit Period
One year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Member’s Effective Date. It does not continue after a Member’s coverage ends.

Brand Name Drug
The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a pharmaceutical manufacturer’s own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own brand name, or under the drug’s chemical name (Generic).

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 Members 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.
Claims Administrator
The company the Plan Sponsor chose to administer its health benefits. Community Insurance Company e.g. 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
If a Member’s coverage is limited to a certain percentage, for example 90%, then the remaining 10% for which the Member is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

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

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

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

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

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

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 cost-sharing arrangement in which a Member pays a specified charge for a Covered Service, such as the Copayment indicated in the Schedule of Benefits for an office visit. The Member is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the provider when services are rendered.

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, lpectomy, 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 Dependent
Any Dependent in a Subscriber’s family who meets all the requirements of the Eligibility section of this Benefit Booklet, has enrolled in the Plan, and is subject to Administrative Service Fee requirements set forth by the Plan.

Covered Services
Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Member’s Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

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 Member 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 Member’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 Member, 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 portion of the bill You must pay before Your medical expenses become Covered Services. It usually is applied on a calendar year basis.

Dependent
The Spouse or same and opposite sex Domestic Partner and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children that live with the Employee and for whom the Employee is the primary source of financial support, and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Mentally retarded or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child’s incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

Domestic Partner
Your same or opposite sex Domestic Partner who meets all the requirements on a Declaration of Domestic Partnership Form. You and Your Domestic Partner must submit an accurate and completed Declaration of Partnership Form, and meet all the requirements listed on this form. Continued eligibility of Your Domestic Partner depends upon the continuing accuracy of this form. Domestic Partner eligibility ends on the date a Domestic Partner no longer meets all the requirements listed on this form.
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.

Durable Medical Equipment
Equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease of 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 Member 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 Member to a later point in time.

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

Employee
A person who is engaged in active employment with the Employer and is eligible for Plan coverage under the employment regulations of the Employer. The Employee is also called the Subscriber.

Employer
An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides.

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:

University of Cincinnati
Active Employee PPO Medical Plan
Package 006
Effective January 1, 2016
• 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.

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

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.

Generic Drugs
Drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicates those of a Brand Name Drug and is its bioequivalent, Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

Group Health Plan or Plan
An employee welfare benefit plan (as defined in Section 3(1) of ERISA), established by the Employer, in effect as of the Effective Date.

Home Delivery (Mail Service)
A Prescription Drug program which offers a convenient means of obtaining maintenance medications by mail if the Member takes Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Home Delivery (Mail Service), which has entered into a reimbursement agreement with the Claims Administrator and sent directly to the Member's home.

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

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

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

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

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

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

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

Infertile or Infertility
The condition of a presumably healthy Member 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.

Initial Enrollee
A person actively employed by the Employer (or one of that person’s Covered Dependents) who was either previously enrolled under the group coverage which this Plan replaces or who is eligible to enroll on the Effective Date of this Plan.

Injury
Bodily harm from a non-occupational accident.

Inpatient
A Member 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.
Late Enrollees
Late Enrollees mean Employees or Dependents who request enrollment in a health benefit plan after the initial open enrollment period. An individual will not be considered a Late Enrollee if: (a) the person enrolls during his/her initial enrollment period under the Plan; (b) the person enrolls during a special enrollment period; or (c) a court orders that coverage be provided for a minor Covered Dependent under a Member's Plan, but only as long as the Member requests enrollment for such Dependent within thirty-one (31) days after the court order is so issued. Late Enrollees are those who declined coverage during the initial open enrollment period and did not submit a certification to the Plan that coverage was declined because other coverage existed.

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 Member under the Plan.

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

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

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

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

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

Member
Individuals, including the Subscriber and his/her Dependents, who have satisfied the Plan eligibility requirements of the Employer, applied for coverage, and been enrolled for Plan benefits.
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 Members through negotiated reimbursement arrangements.

New Hire
A person who is not employed by the Employer on the original Effective Date of the 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 Members at the time services are rendered.

Benefit payments and other provisions of this Plan are limited when a Member uses the services of Out-of-Network Providers.

Out-of-Pocket Maximum
The maximum amount of a Member’s Coinsurance payments during a given calendar year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services.

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 arrangement chosen by the Plan Sponsor to fund and provide for delivery of the Employer’s health benefits.

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

Plan Sponsor
The legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination. The Plan Sponsor is not the Claims Administrator.
Prescription Drug (Drug) (Also referred to as Legend Drug)
A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when one or more ingredients are FDA-approved, require a Prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
- Insulin.

Prescription Order or Prescription
A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician
A provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization
The process applied to certain 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.

Provider
A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this Benefit Booklet. If You have a question if a Provider is covered, please call the number on the back of Your ID Card.

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 health benefit plan to receive benefits for which the Employee is entitled under the plan; and includes the name and last known address of the 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 each 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 group health plan Member 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 a group health plan.

Retail Health Clinic
A facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

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

Skilled Nursing Facility
An institution operated alone or with a Hospital which gives care after a Member leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or otherwise determined by the Claims Administrator to meet the reasonable standards applied by any of the aforesaid authorities.

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

Specialty Drugs
Typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require preauthorization to be considered Medically Necessary.

Spouse
For the purpose of this Plan, a Spouse is defined as shown in the Eligibility section of this Benefit Booklet.

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 the Blue Cross and Blue Shield Association.

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.

Utilization Review
A function performed by the Claims Administrator or by an organization or entity selected by the Claims Administrator to review and approve whether the services provided are Medically Necessary, including but not limited to, whether acute hospitalization, length of stay, Outpatient care or diagnostic services are appropriate.
You and Your
Refer to the Subscriber, Member and each Covered Dependent.
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, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your 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., Your Physician, nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain Precertification. For information on Precertification, contact Your 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 Your 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 Your employer 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.

Special Enrollment Notice
If You are declining enrollment for Yourself or Your Dependents (including Your Spouse) because of other health insurance coverage, You may in the future be able to enroll Yourself or Your Dependents in this Plan, if You or Your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards Your or Your Dependents’ other coverage). However, You must request enrollment within 31 days after Your or Your Dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if You have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, You may be able to enroll Yourself and Your Dependents. However, You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Employees and Dependents may also enroll under two additional circumstances:
• the Employee’s or Dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
• the Employee or Dependent becomes eligible for a subsidy (state premium assistance program).

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call the Customer Service telephone number on Your ID Card, or contact Your Plan Administrator.
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