

# HEALTH BENEFIT BOOKLET

**Kent State University  
90/70 & 80/60 PPO Option**



**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.**

## **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 8:00 p.m. eastern time). Please remember that a benefits inquiry or verification of benefits is NOT a verification of coverage of a specific medical procedure. Verification of benefits is NOT a guarantee of payment. **CALL THE CUSTOMER SERVICE NUMBER ON YOUR IDENTIFICATION CARD** or see the section titled Health Care Management for Precertification rules.

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## **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](http://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.

## 90/70 PPO SCHEDULE OF BENEFITS

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

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

<b>Benefit Period</b>	<b>Calendar Year</b>	
<b>Deductible</b>	<b>Network</b>	<b>Non-Network</b>
Per Person	\$250	\$250
Per Family	\$500	\$500
<b>Out-of-Pocket Limit</b> (includes Deductible)	<b>Network</b>	<b>Non-Network</b>
Per Person	\$1,000	\$1,750
Per Family	\$2,000	\$3,500

Note: The Out-of-Pocket Limit includes all Deductibles and/or Coinsurance percentages you incur in a Benefit Period. Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period.

Network and Non-Network Deductibles, Coinsurance, and Out-of-Pocket Limits **accumulate toward each other.** The Deductible(s) apply only to Covered Services with a percentage Coinsurance.

**Lifetime Maximum for All Covered Services**      Unlimited  
(Network and Non-Network)

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<u>Covered Services</u>	<u>Copayments/Maximums</u>	
	Network	Non-Network
<b>Preventive Care</b>		
• Routine Physical Exam	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	Not Covered
• Routine Testing (5 standard)	Covered in Full up to the Maximum Allowable Amount	Not Covered
• Well Child Care (birth to age 18)	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	30% Coinsurance
• Immunizations	Covered in Full up to the Maximum Allowable Amount	30% Coinsurance
• Routine Mammogram	Covered in Full up to the Maximum Allowable Amount	30% Coinsurance, no deductible
• Routine Pap Test	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	30%, Coinsurance, no deductible
• Routine PSA	Covered in Full up to the Maximum Allowable Amount	30% Coinsurance, no deductible
• Routine Hearing Exam	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	30%, Coinsurance, no deductible
<b>Physician Office Services</b>	\$15 Copayment	30% Coinsurance
Live Health Online visits	\$15 Copayment	30% Coinsurance
Specialist (includes Chiropractors)	\$30 Copayment	30% Coinsurance
<b>Inpatient Services</b>	10% Coinsurance	30% Coinsurance
Second Surgical Opinion	Covered in Full up to the Maximum Allowable Amount	30% Coinsurance
Maximum days per Benefit Period for Physical Medicine and Rehabilitation	unlimited	

<b>Skilled Nursing Facility</b> Maximum days per Benefit Period for Skilled Nursing Care Facility Services	10% Coinsurance  120 days	10% Coinsurance
<b>Inpatient Facility Services</b>	10% Coinsurance	\$100 Copayment, plus 30% Coinsurance
<b>Outpatient Facility Services</b>	10% Coinsurance	30% Coinsurance
<b>Therapy Services</b> (when rendered as Physician's Office Services or Outpatient Facility Services)	10% Coinsurance	30% Coinsurance

**NOTE:** If different types of Therapy Services are performed during one Physician Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Spinal Manipulation service are performed during one Physician Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Spinal Manipulation Visit.

Maximum Visits per Benefit  
Period for:

Physical & Occupational Therapy	unlimited
Speech Therapy	unlimited

Other Therapy Services:

Spinal Manipulations	\$30 Copayment	30% Coinsurance
Maximum visits per Benefit Period for Spinal Manipulations	20 visits	

(when rendered as Physician's  
Office Services or Outpatient  
Facility Services)

Network Copayment/ Coinsurance based on setting where Covered Services are received	Non-Network Coinsurance based on setting where Covered Services are received
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**Diagnostic Services**

When rendered as Physician Office Services or Outpatient Services the Copayment/Coinsurance is based on the setting where Covered Services are received.

**Emergency Room Services**  
(If admitted directly from the  
Emergency Room, the

10% Coinsurance	10% Coinsurance
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Emergency Room Copayment  
for that visit is waived)

<b>Non-Emergency – Emergency Room Facility Services</b>	<b>Not Covered</b>	<b>Not Covered</b>
<b>Non-Emergency – Emergency Room Physician Services Only</b>	\$50 Copayment, plus deductible and 10% Coinsurance	\$50 Copayment, plus deductible and 30% Coinsurance
<b>Urgent Care Center Services</b>	\$15 Copayment	30% Coinsurance
<b>Ambulance Services</b>	10% Coinsurance	10% Coinsurance
<b>Home Care Services</b> Maximum Visits per Benefit Period	10% Coinsurance 120 visits	10% Coinsurance
<b>Hospice Services</b>	10% Coinsurance	10% Coinsurance
<b>Medical Supplies, Durable Medical Equipment and Appliances</b>	10% Coinsurance	10% Coinsurance
<b>NOTE:</b> Physician office Copayments are applied rather than the Network Copayment listed above if medical supplies, Durable Medical Equipment or appliances are obtained in a Network Physician's office.		
<b>Maternity Services</b>	10% Coinsurance	30% Coinsurance
<b>Nutritional Therapy (including for the diagnosis of eating disorders) and Diabetic Management Counseling Services</b>	10% Coinsurance	30% Coinsurance
<b>Behavioral Health/Substance Abuse Services</b>		
<b>Hospital Inpatient Services (including Residential Treatment Centers)</b>	10% Coinsurance	\$100 Copayment, then 30% Coinsurance
<b>Outpatient Services</b>	10% Coinsurance	30% Coinsurance
<b>Physician Services (Home and Office</b>	\$15 Copayment	30% Coinsurance

**Visits)**

**Methadone and  
Heroin Addiction  
Clinics**

Network Copayment/  
Coinsurance based on setting  
where Covered Services are  
received

Non-Network Coinsurance  
based on setting where  
Covered Services are  
received

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

**Human Organ and Tissue  
Transplant Services**

Human Organ Transplants  
Tissue Transplants

10% Coinsurance  
Coinsurance based on setting  
where Covered Services are  
received

30% Coinsurance  
Coinsurance based on  
setting where Covered  
Services are received

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**NETWORK  
TRANSPLANT FACILITY**

**NON-NETWORK  
TRANSPLANT FACILITY**

**Transportation and Lodging**

10% Coinsurance

30% of Maximum  
Allowable Amount

Reasonable and necessary travel expenses related to a transplant at a Non-Network Transplant Facility are covered at the Non-Network Transplant Facility Coinsurance level.

## 80/60 PPO SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Copayments and other limits when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any attachments or riders. **This Schedule of Benefits lists the Member's responsibility for Covered Services and supplies.**

<b>Benefit Period</b>	<b>Calendar Year</b>	
<b>Deductible</b>	<b>Network</b>	<b>Non-Network</b>
Per Person	\$350	\$350
Per Family	\$700	\$700
<b>Out-of-Pocket Limit</b> (includes Deductible)	<b>Network</b>	<b>Non-Network</b>
Per Person	\$1,250	\$2,350
Per Family	\$2,500	\$4,700

Note: The Out-of-Pocket Limit includes all Deductibles and/or Coinsurance percentages you incur in a Benefit Period. Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period.

Network and Non-Network Deductibles, Coinsurance, and Out-of-Pocket Limits **accumulate toward each other.** The Deductible(s) apply only to Covered Services with a percentage Coinsurance.

**Lifetime Maximum for All Covered Services**      Unlimited  
(Network and Non-Network)

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<u>Covered Services</u>	<u>Copayments/Maximums</u>	
	Network	Non-Network
<b>Preventive Care</b>		
• Routine Physical Exam	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	Not Covered
• Routine Testing (5 standard)	Covered in Full up to the Maximum Allowable Amount	Not Covered
• Well Child Care (birth to age 18)	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	40% Coinsurance
• Immunizations	Covered in Full up to the Maximum Allowable Amount	40% Coinsurance
• Routine Mammogram	Covered in Full up to the Maximum Allowable Amount	40% Coinsurance, no deductible
• Routine Pap Test	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	40%, Coinsurance, no deductible
• Routine PSA	Covered in Full up to the Maximum Allowable Amount	40% Coinsurance, no deductible
• Routine Hearing Exam	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	40%, Coinsurance, no deductible
<b>Physician Office Services</b>	\$15 Copayment	40% Coinsurance
<b>Live Health Online visits</b>	\$15 Copayment	40% Coinsurance
<b>Physician Office Services</b>	\$15 Copayment	40% Coinsurance
Specialist (includes Chiropractors)	\$30 Coinsurance	40% Coinsurance
<b>Inpatient Services</b>	20% Coinsurance	40% Coinsurance
Second Surgical Opinion	Covered in Full up to the Maximum Allowable Amount	40% Coinsurance
Maximum days per Benefit	unlimited	

<u>Covered Services</u>	<u>Copayments/Maximums</u>	
	Network	Non-Network
Period for Physical Medicine and Rehabilitation		
<b>Skilled Nursing Facility</b>	20% Coinsurance	20% Coinsurance
Maximum days per Benefit	120 days	
Period for Skilled Nursing Care Facility Services		
<b>Inpatient Facility Services</b>	20% Coinsurance	\$100 Copayment, plus 40% Coinsurance
<b>Outpatient Facility Services</b>	20% Coinsurance	40% Coinsurance
<b>Therapy Services (when rendered as Physician's Office Services or Outpatient Facility Services)</b>	20% Coinsurance	40% Coinsurance
<p><b>NOTE:</b> If different types of Therapy Services are performed during one Physician Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Spinal Manipulation service are performed during one Physician Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Spinal Manipulation Visit.</p>		
Maximum Visits per Benefit		
Period for:		
Physical & Occupational Therapy	unlimited	
Speech Therapy	unlimited	
Other Therapy Services:		
<b>Spinal Manipulations</b>	\$30 Copayment	40% Coinsurance
Maximum visits per Benefit	20 visits	
Period for Spinal Manipulations		
(when rendered as Physician's Office Services or Outpatient Facility Services)	Network Copayment/Coinsurance based on setting where Covered Services are received	Non-Network Coinsurance based on setting where Covered Services are received
<b>Diagnostic Services</b>	When rendered as Physician Office Services or Outpatient Services the Copayment/Coinsurance is based on the setting where Covered Services are received.	

<u>Covered Services</u>	<u>Copayments/Maximums</u>	
	<u>Network</u>	<u>Non-Network</u>
<b>Emergency Room Services</b> (If admitted directly from the Emergency Room, the Emergency Room Copayment for that visit is waived)	20% Coinsurance	20% Coinsurance
<b>Non-Emergency – Emergency Room Facility Services</b>	<b>Not Covered</b>	<b>Not Covered</b>
<b>Non-Emergency – Emergency Room Physician Services Only</b>	\$50 Copayment, Plus deductible and 20% Coinsurance	\$50 Copayment, Plus deductible and 40% Coinsurance
<b>Urgent Care Center Services</b>	\$15 Copayment	40% Coinsurance
<b>Ambulance Services</b>	20% Coinsurance	20% Coinsurance
<b>Home Care Services</b> Maximum Visits per Benefit Period	20% Coinsurance  120 visits	20% Coinsurance
<b>Hospice Services</b>	20% Coinsurance	20% Coinsurance
<b>Medical Supplies, Durable Medical Equipment and Appliances</b>	20% Coinsurance	20% Coinsurance
<b>NOTE:</b> Physician office Copayments are applied rather than the Network Copayment listed above if medical supplies, Durable Medical Equipment or appliances are obtained in a Network Physician's office.		
<b>Maternity Services</b>	20% Coinsurance	40% Coinsurance
<b>Nutritional Therapy and Diabetic Management Counseling Services</b>	20% Coinsurance	40% Coinsurance
<b>Behavioral Health/Substance Abuse Services</b>		
<b>Hospital Inpatient     Services (including     Residential Treatment     Centers)</b>	20% Coinsurance	\$100 Copayment, then 40% Coinsurance

**Covered Services****Copayments/Maximums****Outpatient Services****Network**  
20% Coinsurance**Non-Network**  
40% Coinsurance**Physician Services  
(Home and Office  
Visits)**

\$15 Copayment

40% Coinsurance

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

**Human Organ and Tissue  
Transplant Services**Human Organ Transplants  
Tissue Transplants20% Coinsurance  
Coinsurance based on setting  
where Covered Services are  
received40% Coinsurance  
Coinsurance based on  
setting where Covered  
Services are received

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**NETWORK  
TRANSPLANT FACILITY****NON-NETWORK  
TRANSPLANT FACILITY****Transportation and Lodging**

20% Coinsurance

40% of Maximum  
Allowable Amount

Reasonable and necessary travel expenses related to a transplant at a Non-Network Transplant Facility are covered at the Non-Network Transplant Facility Coinsurance level.

## 70/50 PPO SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Copayments and other limits when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any attachments or riders. **This Schedule of Benefits lists the Member's responsibility for Covered Services and supplies.**

<b>Benefit Period</b>	<b>Calendar Year</b>	
<b>Deductible</b>	<b>Network</b>	<b>Non-Network</b>
Per Person	\$500	\$500
Per Family	\$1,000	\$1,000
<b>Out-of-Pocket Limit</b> (includes Deductible)	<b>Network</b>	<b>Non-Network</b>
Per Person	\$1,500	\$3,000
Per Family	\$3,000	\$6,000

Note: The Out-of-Pocket Limit includes all Deductibles and/or Coinsurance percentages you incur in a Benefit Period. Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the Member and/or family for the remainder of the Benefit Period.

Network and Non-Network Deductibles, Coinsurance, and Out-of-Pocket Limits **accumulate toward each other.** The Deductible(s) apply only to Covered Services with a percentage Coinsurance.

**Lifetime Maximum for All Covered Services**      Unlimited  
(Network and Non-Network)

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<u>Covered Services</u>	<u>Copayments/Maximums</u>	
	Network	Non-Network
<b>Preventive Care</b>		
• Routine Physical Exam	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	Not Covered
• Routine Testing (5 standard)	Covered in Full up to the Maximum Allowable Amount	Not Covered
• Well Child Care (birth to age 18)	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	50% Coinsurance
• Immunizations	Covered in Full up to the Maximum Allowable Amount	50% Coinsurance
• Routine Mammogram	Covered in Full up to the Maximum Allowable Amount	50% Coinsurance, no deductible
• Routine Pap Test	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	50%, Coinsurance, no deductible
• Routine PSA	Covered in Full up to the Maximum Allowable Amount	50% Coinsurance, no deductible
• Routine Hearing Exam	\$15 Copayment, then Covered in Full up to the Maximum Allowable Amount	50%, Coinsurance, no deductible
<b>Physician Office Services</b>	\$15 Copayment	50% Coinsurance
<b>Live Health Online visits</b>	Not Covered	Not Covered
<b>Physician Office Services</b>	\$15 Copayment	50% Coinsurance
Specialist (includes Chiropractors)	\$30 Coinsurance	50% Coinsurance
<b>Inpatient Services</b>	30% Coinsurance	50% Coinsurance
Second Surgical Opinion	Covered in Full up to the Maximum Allowable Amount	50% Coinsurance
Maximum days per Benefit	unlimited	

<u>Covered Services</u>	<u>Copayments/Maximums</u>	
	Network	Non-Network
Period for Physical Medicine and Rehabilitation		
<b>Skilled Nursing Facility</b>	30% Coinsurance	30% Coinsurance
Maximum days per Benefit	120 days	
Period for Skilled Nursing Care Facility Services		
<b>Inpatient Facility Services</b>	30% Coinsurance	\$100 Copayment, plus 50% Coinsurance
<b>Outpatient Facility Services</b>	30% Coinsurance	50% Coinsurance
<b>Therapy Services (when rendered as Physician's Office Services or Outpatient Facility Services)</b>	30% Coinsurance	50% Coinsurance
<p><b>NOTE:</b> If different types of Therapy Services are performed during one Physician Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Spinal Manipulation service are performed during one Physician Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Spinal Manipulation Visit.</p>		
Maximum Visits per Benefit		
Period for:		
Physical & Occupational Therapy	unlimited	
Speech Therapy	unlimited	
Other Therapy Services:		
<b>Spinal Manipulations</b>	\$30 Copayment	50% Coinsurance
Maximum visits per Benefit	20 visits	
Period for Spinal Manipulations		
(when rendered as Physician's Office Services or Outpatient Facility Services)	Network Copayment/Coinsurance based on setting where Covered Services are received	Non-Network Coinsurance based on setting where Covered Services are received
<b>Diagnostic Services</b>	When rendered as Physician Office Services or Outpatient Services the Copayment/Coinsurance is based on the setting where Covered Services are received.	

<u>Covered Services</u>	<u>Copayments/Maximums</u>	
	<u>Network</u>	<u>Non-Network</u>
<b>Emergency Room Services</b> (If admitted directly from the Emergency Room, the Emergency Room Copayment for that visit is waived)	30% Coinsurance	30% Coinsurance
<b>Non-Emergency – Emergency Room Facility Services</b>	<b>Not Covered</b>	<b>Not Covered</b>
<b>Non-Emergency – Emergency Room Physician Services Only</b>	\$50 Copayment, Plus deductible and 30% Coinsurance	\$50 Copayment, Plus deductible and 50% Coinsurance
<b>Urgent Care Center Services</b>	\$15 Copayment	50% Coinsurance
<b>Ambulance Services</b>	30% Coinsurance	30% Coinsurance
<b>Home Care Services</b> Maximum Visits per Benefit Period	30% Coinsurance  120 visits	30% Coinsurance
<b>Hospice Services</b>	30% Coinsurance	30% Coinsurance
<b>Medical Supplies, Durable Medical Equipment and Appliances</b>	30% Coinsurance	30% Coinsurance
<b>NOTE:</b> Physician office Copayments are applied rather than the Network Copayment listed above if medical supplies, Durable Medical Equipment or appliances are obtained in a Network Physician's office.		
<b>Maternity Services</b>	First visit: \$15/\$30 Copayment Visits and other services thereafter: 20% Coinsurance	50% Coinsurance
<b>Nutritional Therapy and Diabetic Management Counseling Services</b>	30% Coinsurance	50% Coinsurance
<b>Behavioral Health/Substance Abuse Services</b>		Behavioral Health: \$100 Copayment, then 50% Coinsurance
<b>Hospital Inpatient Services (including Residential Treatment Centers)</b>	30% Coinsurance	Substance Abuse:

<u>Covered Services</u>	<u>Copayments/Maximums</u>	
	<b>Network</b>	<b>Non-Network</b> 50% Coinsurance
<b>Outpatient Services</b>	30% Coinsurance	50% Coinsurance
<b>Physician Services (Home and Office Visits)</b>	\$15 Copayment	50% Coinsurance

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

### **Human Organ and Tissue Transplant Services**

Human Organ Transplants	30% Coinsurance	50% Coinsurance
Tissue Transplants – including Bone Marrow donor search fee limited to \$30,000 per transplant	Coinsurance based on setting where Covered Services are received	Coinsurance based on setting where Covered Services are received
	<b>NETWORK TRANSPLANT FACILITY</b>	<b>NON-NETWORK TRANSPLANT FACILITY</b>
<b>Transportation and Lodging</b> – limited to a maximum of \$10,000 per transplant	30% Coinsurance	50% of Maximum Allowable Amount

Reasonable and necessary travel expenses related to a transplant at a Non-Network Transplant Facility are covered at the Non-Network Transplant Facility Coinsurance level.

# 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.

## DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

**Actively at Work** - Present and capable of carrying out the normal assigned job duties of the Employer. Subscribers who are absent from work due to a health-related disability, maternity leave or regularly scheduled vacation will be considered Actively at Work.

**Administrative Services Agreement** - The agreement between the 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.

**Administrator** - An organization or entity that the Employer contracts with to provide administrative and claims payment services under the Plan. The Administrator is Community Insurance Company. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

**Alternate Recipient** - Any child of a Subscriber who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under the Plan with regard to such Subscriber.

**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 Administrator to be paid at the Network level. The Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable 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 Booklet** - This summary of the terms of your health benefits.

**Benefit Period** - The period of time that benefits for Covered Services are payable under the Plan. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

**Card Holder** - an eligible employee or COBRA participant who has enrolled for coverage under the terms and conditions of the Plan.

**Copayment** - A specific dollar amount of Maximum Allowable Amounts for Covered Services indicated in the Schedule of Benefits for which you are responsible. The Copayment does not apply towards any Deductible or Out-of-Pocket Maximum. Your flat dollar Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

**Coinsurance** - A specific percentage of the Maximum Allowable Amount for Covered Services that is indicated in the Schedule of Benefits (%), which you must pay. Coinsurance normally applies after the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions.

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

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

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

**Covered Transplant Procedure** - Any Medically Necessary human organ and tissue transplant as determined by the Administrator, on behalf of the Employer, including necessary acquisition costs and preparatory myeloblastic therapy.



**Covered Transplant Services** - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

**Custodial Care** - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

**Deductible** - The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before benefits are payable under the Plan for Covered Services each Benefit Period.

**Dependent** - A person of the Subscriber's family who is eligible for coverage under the Plan.

**Diagnostic Service** - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition or a test performed as a Medically Necessary preventive care screening for an asymptomatic patient. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

**Domestic Partner** - Two adults who meet the plan sponsor's eligibility requirements and have been registered and approved for coverage by the plan sponsor.

**Domiciliary Care** – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

**Effective Date** - The date your coverage begins under the Plan. You must be Actively at Work on your Effective Date. If you are not Actively at Work on your Effective Date, your Effective Date will be the date you become Actively at Work. A Dependent's coverage under the Plan begins on the Effective Date of the sponsoring Subscriber. No benefits are payable for services and supplies received before your Effective Date or after your termination date.

**Eligible Person** - A person who satisfies the Employer's eligibility requirements and is entitled to apply to be a Subscriber.

**Emergency** - An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

**Emergency Care** - Covered Services that are furnished by a Provider within the scope of the Provider's license and as otherwise authorized by law that are needed to evaluate or Stabilize an individual in an Emergency.

**Employer** – The legal entity contracting with the Administrator for administration of group health care benefits. The Employer is Kent State University.

**Enrollment Date** - The first day of coverage under the Plan or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

**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 Administrator or the

Administrator's designee, on behalf of the Employer, determines in its sole discretion to be Experimental/Investigative. The Administrator, on behalf of the Employer, will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Administrator, on behalf of the Employer, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; 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 Administrator, on behalf of the Employer. In determining whether a Service is Experimental/Investigative, the Administrator, on behalf of the Employer, 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 Administrator, on behalf of the Employer, 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.

**Family Coverage** – Coverage provided by the Employer for the Subscriber and eligible Dependents.

**Fee(s)** - The periodic charges which are required to be paid by you and/or the Employer to maintain benefits under the Plan.

**Identification Card** - A card issued by the Administrator, on behalf of the Employer, that bears the Member's name, identifies the membership by number, and may contain information about your benefits under the Plan. It is important to carry this card with you.

**Inpatient** - A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

**Late Enrollee** - An individual whose enrollment under the Plan is a Late Enrollment.

**Late Enrollment** - Enrollment other than on:

- The earliest date on which benefits can become effective under the Plan; or
- The date of an event that qualifies for Special Enrollment.

**Lifetime Maximum** - The maximum dollar amount for Covered Services paid by the Plan during your lifetime.

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

**Medically Necessary or Medical Necessity** – 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 Administrator, on behalf of the Employer, 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 mean lowest cost);
- 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.

**Medicare** - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

**Member** - A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Employer and for whom Fee payment has been made. Members are sometimes called “you” or “your.”

**Network Provider** - A Provider who has entered into a contractual agreement or is otherwise engaged by the Administrator, or with another organization which has an agreement with the Administrator, regarding payment for Covered Services and certain administration functions for the Network associated with the Plan.

**Network Transplant Facility** – A Provider who has entered into a contractual agreement or is otherwise engaged by the Administrator, on behalf of the Employer, or with another organization which has an agreement with the Administrator, on behalf of the Employer, to provide Covered Services and certain administrative functions to you for the network associated with this Benefit Booklet. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

**New FDA Approved Drug Product or Technology** - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced Generic medication (Generic medications contain the same active ingredient as their counterpart brand-named medications).

**Non-Network Provider** - A Provider who has not entered into a contractual agreement with Administrator, on behalf of the Employer, or is not otherwise engaged by Administrator, on behalf of the Employer, for the network associated with this Plan. Providers who have not contracted or affiliated with Administrator's designated Subcontractor(s) for the services they perform under this Plan are also considered Non-Participating/Network Providers.

**Non-Network Transplant Facility** - Any Hospital which has not contracted with the transplant network engaged by Administrator, on behalf of the Employer, to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

**Out-of-Pocket Limit** - A specified dollar amount of expense incurred for Covered Services in a Benefit Period as listed in the Schedule of Benefits. Such expense does not include charges in excess of the Maximum Allowable Amount or any non-Covered Services. Refer to the Schedule of Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Coinsurance is required unless otherwise specified in this Benefit Booklet.

**Outpatient** - A Member who receives services or supplies while not an Inpatient.

**Pharmacy and Therapeutics Committee** - a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

**Plan** – The group health benefit Plan provided by the Employer and explained in this Benefit Booklet.

**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 include, but are not limited to, the following persons and facilities:

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
  1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
  2. Surgery;
  3. Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility** - A Provider that:

1. is licensed as such, where required;
  2. is equipped mainly to do Surgery;
  3. has the services of a Physician and a Registered Nurse (R.N.) at all times when a patient is present;
  4. is not an office maintained by a Physician for the general practice of medicine or dentistry; and
  5. is equipped and ready to initiate Emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills.
- **Birth Center** - a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
      - a. provide care at childbirth;
      - b. are practicing within the scope of their training and experience; and
      - c. are licensed if required; and
    4. equipped and ready to initiate Emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.
  - **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.
  - **Home Health Care Agency** - A public or private agency or organization licensed and accredited in the state in which it is located to provide Home Health Care Services.



- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing and accrediting requirements of the state or locality in which it operates.
- **Hospital** - A Provider constituted, licensed, accredited, and operated as set forth in the laws that apply to Hospitals, which:
  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;
  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

1. nursing care;
2. rest care;
3. convalescent care;
4. care of the aged;
5. Custodial Care;
6. educational care;
7. treatment of alcohol abuse; or
8. treatment of drug abuse.

- **Physician -**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
2. any other legally licensed practitioner of the healing arts rendering services which are:
  - a. covered by the Plan;
  - b. required by law to be covered when rendered by such practitioner; and
  - c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Specialist (Specialty Care Physician\Provider or SCP)**

1. 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.

- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial Provider or similar place.

- **Urgent Care Center** - A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

**Recovery** – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist," "Underinsured Motorist," "Medical-Payments," "No-Fault," or "Personal Injury Protection," or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the

money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Benefit Booklet.

**Service Area** - The geographical area within which Covered Services under the Plan are available.

**Single Coverage** – Coverage for the Subscriber only.

**Skilled Care** - Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

**Stabilize** - The provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an Emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an Emergency department or other care setting to another facility; or
- your transfer from a Hospital Emergency department or other Hospital care setting to the Hospital's Inpatient setting.

**Subcontractor** - The Administrator and/or Employer may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and Mental Health/behavioral health and Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Administrator's or Employer's behalf.

**Subscriber** - An eligible employee or retired employee or Member of the Employer enrolled under the Plan, whose benefits are in effect and whose name appears on the Identification Card issued by the Administrator, on behalf of the Employer.

**Therapy Services** - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

## **ELIGIBILITY, ENROLLMENT, TERMINATION, CONTINUATION AND CONVERSION**

### **Eligibility**

Benefits payable under the Plan are available to you because of your employment with, or membership with, or retirement from the Employer.

In order for you to participate in the Plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods. The specific time periods and other standards for participation in the Plan are determined by the Employer or federal law.

You are eligible to participate in this Plan if you are full-time employee of Kent State University and it is determined that your place of residence is in the service area covered under this Plan. Your eligibility date is the later of: 1.) the Effective Date of this Plan; or 2.) the date you commence full-time employment at Kent State University.

### **Dependents**

You may cover your:

- wife, husband and/or Domestic Partner (same or opposite sex); For the purposes of this Plan, a Spouse is defined as a person who is recognized under the laws of the state where the enrolling Employee lives.
- children until the end of the month in which they turn age 26, unless otherwise indicated by AFSCME or AAUP agreements.
- any eligible dependent between the ages of 26-28 who were on the plan prior to 12/31/2015 remain an eligible dependent. Also, per agreement, eligible dependents of Tenured and Tenure-Track Faculty may remain on the plan until age 28.

Your children include your;

- Your biological children.
- Your legally adopted children.
- Your stepchildren.
- Children you or your spouse have legal guardianship/custodianship.
- Foster children that live with the Employee and for whom the Employee is the primary source of financial support

No person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee. Eligibility will continue past the age limit for Eligible Dependents who are primarily dependent upon the Card Holder for support due to a mental or physical disability which renders them unable to work. This incapacity must be medically certified by a Physician. You must notify your Plan Sponsor of the Eligible Dependent's desire to continue coverage within 31 days of reaching the limiting age. After a two-year period following the date the Eligible Dependent meets the age limit, the Plan may annually require further proof that the dependence and incapacity continue. You must notify the Claims Administrator and/or the Employer if the Dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage.

## **Qualified Medical Child Support Order**

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable federal law, to enroll your child under the Plan, the Employer will permit your child to enroll at any time without regard to any open enrollment limits and shall provide the benefits of the Plan in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond any Dependent Age Limit listed in the Schedule of Benefits. Any claims payable under the Plan will be paid, at the Plan's discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. The Administrator, on behalf of the Employer, will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Employer or Administrator directly.

## **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.

## **Late Enrollment**

An Eligible Person or Dependent who did not request enrollment for coverage with the Plan during the initial enrollment period, as a newly eligible person, or a special enrollment period during which the individual was entitled to enroll is considered a Late Enrollee and not eligible to enroll for coverage with the Plan until the next Open Enrollment Period.

## **Open Enrollment**

An Open Enrollment Period shall be held at least once every 12 consecutive months. Eligible Members and their eligible Dependents may enroll during this period. Open Enrollment means a period of time which is held no less frequently than once in any 12 consecutive months.

## **Effective Date of Coverage**

Your Effective Date is the first day of your full-time employment after you first become eligible (see page 31), you enroll in an initial, Open or Special Enrollment and you arrange to make the necessary employee contributions for your coverage.

## **Termination**

Your benefits will be terminated at the end of the month in which one of the following occurs:

- Your employment with Kent State University ends;
- You begin working in a position at Kent State University which does not meet the eligibility requirements for coverage;
- You fail to make the contributions required by your enrollment.

## **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.

## **Federal Continuation of Coverage (COBRA)**

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

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

## **COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of health coverage under the Employer's health Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, 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 coverage under the Employer's

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

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

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

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

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

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

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

### **When is COBRA Coverage Available**

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

**You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Employer within 30 days after the qualifying event occurs.

**How is COBRA Coverage Provided**

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

COBRA continuation coverage is a temporary continuation of coverage.

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

**Disability extension of 18-month period of continuation coverage**

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



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

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

### **If You Have Questions**

Questions concerning your Employer's health Plan and your COBRA continuation coverage rights should be addressed to the Employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting Employer 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](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### **Continuation of Coverage due to Military Service**

In the event you are no longer Actively at Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under the Plan in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

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

You may elect to continue to cover yourself and your eligible Dependents (if any) under the Plan by notifying your Employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If Your military service is for a period of time less than 31 days, You may not be required to pay more than the active Member contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under the Plan shall be the lesser of:

- The 24-month period beginning on the first date of your absence from work; or
- The day after the date on which You fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your eligible

Dependents in connection with this reinstatement unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

## HOW YOUR PLAN WORKS

### Network Services

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

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

To see a Doctor, call their office:

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

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

For services from Network Providers:

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

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

### After Hours Care

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

### Out-of-Network Services

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

For services from an Out-of-Network Provider:

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

### **How to Find a Provider in the Network**

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

- See Your Plan's directory of Network Providers at [www.anthem.com](http://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.

### **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.

### **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.

### **Not Liable for Provider Acts or Omissions**

The Administrator and/or the Employer are not responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Administrator and/or the Employer based on what a Provider of health care, services or supplies, does or does not do.

### **Identification Card**

When you receive care from your Network Provider or other Provider, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under the Plan. To be entitled to such services or benefits you must be a Member on whose behalf all applicable Fees under the Plan have been paid. Any person receiving services or other benefits to which he or she is not then entitled under the provisions of the Plan will be responsible for the actual cost of such services or benefits.

### **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.

## HEALTH CARE MANAGEMENT - PRECERTIFICATION

Health Care Management includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review. Its purpose is to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources and optimizing the health of the Members the Claims Administrator serves. These processes are described in the following section.

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](http://www.anthem.com).

### Types of Requests:

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

**Predetermination** – An optional, voluntary Prospective or Concurrent/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.

*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 2 business days after admission)

### **Outpatient Services:**

- Ablative Techniques as a Treatment for Barrett's Esophagus
- Air Ambulance (excludes 911 initiated emergency transport)
- Artificial Intervertebral Discs
- Balloon Sinuplasty
- Bariatric surgery
- 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
- Gender Reassignment Surgery
- 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
  - ▶ Liposuction/Lipectomy
  - ▶ Procedures Performed on Male or Female Genitalia
  - ▶ Procedures Performed on the Face, Jaw or Neck (including facial dermabrasion, scar revision)
  - ▶ Procedures Performed on the Trunk and Groin
  - ▶ Repair of Pectus Excavatum / Carinatum
  - ▶ Rhinoplasty
  - ▶ Skin-Related Procedures
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Private Duty Nursing
- Radiation therapy
  - ▶ Intensity Modulated Radiation Therapy (IMRT)



- ▶ Proton Beam Therapy
- Radiofrequency Ablation to Treat Tumors Outside the Liver
- Real-Time Remote Heart Monitors
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Septoplasty
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Subtalar Arthroereisis
- Suprachoroidal Injection of a Pharmacologic Agent
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other GU Conditions
- Surgical Treatment of Migraine Headaches
- Thoracoscopy for Treatment of Hyperhidrosis
- Tonsillectomy in Children
- Total Ankle Replacement
- Transcatheter Closure of Cardiac Defects
- Transcatheter Uterine Artery Embolization
- Transmyocardial Prepericardial Device
- Tympanostomy Tube Placement for the Treatment of Ménière's Disease
- Treatment of Obstructive Sleep Apnea, UPPP
- Treatment of Osteochondral Defects of the Knee and Ankle
- Treatment of Temporomandibular Disorders
- Vagus Nerve Stimulation
- Varicose Vein Treatment

#### **Human Organ and Bone Marrow/Stem Cell Transplants**

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

#### **Out of Network Referrals:**

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

#### **Mental Health/Substance Abuse:**

##### **Pre-certification Required**

- Acute Inpatient Admissions
- Transcranial Magnetic Stimulation (TMS)

- Intensive Outpatient Therapy (IOP)
- Partial Hospitalization (PHP)
- Residential Care

**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.

<b>Who is responsible for Precertification?</b>	
<b>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.</b>	<b>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.</b>
Provider is responsible for Precertification.	<ul style="list-style-type: none"> <li>• Member is responsible for Precertification.</li> <li>• 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.</li> </ul>

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. 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.

<b>Request Category</b>	<b>Timeframe Requirement for Decision and Notification</b>
Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent/Continued Stay Review when hospitalized at time of request	72 hours from request and prior to expiration of current certification
Other Concurrent/Continued Stay Review Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
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	72 hours from the receipt of the request
Concurrent/Continued Stay Review Non-Urgent for ongoing outpatient treatment	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

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.

## COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **Care must be received from a Network Provider to be covered at the Network level, except for Emergency Care and Urgent Care. Services which are not received from a Network Provider will be considered a Non-Network Service, unless otherwise specified in this Benefit Booklet.** The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider.

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

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Benefit Booklet, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Benefit Booklet, including use of Network Providers, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization/Precertification has been obtained. The Administrator, on behalf of the Employer, bases its decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on the Administrator's medical policy and Clinical Guidelines. The Administrator, on behalf of the Employer, may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

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

## Preventive Care Services

Preventive Care benefits may vary based on the age, sex, and personal history of the individual, and as determined appropriate by the Administrator's clinical coverage guidelines. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. **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.**

Some examples of Preventive Care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. **(Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.)** Examinations include, but are not limited to:
  1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines.
  2. Child health supervision services from the moment of birth until age nine. Child health supervision services mean periodic review of a child's physical and emotional status performed by a physician, by a health care professional under the supervision of a physician, or, in the case of hearing screening, by an individual acting in accordance with Ohio law. Periodic review means a review performed in accordance with the recommendations of the American academy of pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests;
  3. Adult routine physical examinations.
  4. Pelvic examinations.
  5. Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.
  6. Annual dilated eye examination for diabetic retinopathy.
  7. Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follow the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians. These include, but are not limited to:
    - Hepatitis A vaccine
    - Hepatitis B vaccine
    - Hemophilus influenza b vaccine (Hib)
    - Influenza virus vaccine
    - Rabies vaccine
    - Diphtheria, Tetanus, Pertussis vaccine

- Mumps virus vaccine
- Measles virus vaccine
- Rubella virus vaccine
- Poliovirus vaccine

- **Screening examinations:**

1. Routine vision screening for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts;
2. Routine hearing screening.
3. Routine screening mammograms; Additional mammography views required for proper evaluation and any ultrasound services for screening of breast cancer, if determined Medically Necessary by your Physician, are also covered. The total benefit for a screening mammography under this Plan, regardless of the number of claims submitted by Providers, will not exceed one hundred thirty per cent (130%) of the Medicare reimbursement rate in the state of Ohio for a screening mammography. If a Provider, Hospital, or other health care facility provides a service that is a component of the screening mammography and submits a separate claim for that component, a separate payment shall be made to the Provider, Hospital, or other health care facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. The benefit paid for mammography constitutes full payment under this Certificate. No Provider, Hospital, or other health care facility shall seek or receive compensation in excess of the payment made that corresponds to the ratio paid by Medicare in Ohio.
4. Routine cytologic screening for the presence of cervical cancer and chlamydia screening (including pap test);
5. Routine bone density testing for women;
6. Routine prostate specific antigen testing;
7. Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

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

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

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

### **Physician Office Services**

Office Services include care in a Physician's office that is not related to Maternity and Mental



Health Conditions, except as specified. Refer to the sections entitled **Maternity Services** and **Mental Health/Substance Abuse Services other than Biologically Based Mental Illness** for services covered by the Plan. **For Emergency Accident or Medical Care** refer to the **Emergency Care and Urgent Care** section.

**Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits include injections including allergy injections. When an allergy injection or allergy serum is the only charge from a Physician's office, no Copayment is required if stated in dollars. Coinsurances stated as percentages are not waived.

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

**Surgery** and Surgical services including anesthesia and supplies. The surgical fee includes normal post-operative care.

**Therapy Services** for Physical Medicine Therapies and Other Therapies when rendered in the office of a Physician or other professional Provider.

## **Inpatient Services**

Inpatient Services do not include care related to Maternity and Mental Health Conditions, except as specified. Refer to the sections entitled **Maternity Services** and **Mental Health/Substance Abuse Services other than Biologically Based Mental Illness** for services covered by the Plan.

- **Inpatient Services include:**

- charges from a Hospital or other Provider for room, board and general nursing services;
- ancillary services; and
- professional services from a Physician while an Inpatient.

- **Room, Board, and General Nursing Services**

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

- **Ancillary Services**

- operating, delivery and treatment rooms and equipment;

- prescribed drugs;
- anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider;
- medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services; and
- Therapy Services.

#### ○ **Professional Services**

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

#### **Copayment Waiver**

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment stated in dollars per admission in the Schedule of Benefits is waived for the second admission. Copayment stated as a percentage are not waived.

#### **Outpatient Services**

Outpatient Services include **both facility and professional charges** when rendered as an Outpatient at a Hospital, Alternative Care Facility or other Provider as determined by the Plan. Outpatient Services do not include care that is related to Maternity or Mental Health/Substance Abuse Services **other than Biologically Based Mental Illness**, except as otherwise specified. Professional charges only include services billed by a Physician or other professional.

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

#### **Emergency Care and Urgent Care Services**

##### **Emergency Care (including Emergency Room Services)**

Medically Necessary Services which the Administrator, on behalf of the Employer, determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered and reimbursed by the Plan at the Network level. The Member is not required to pay more than would have been required for services from a Network Provider. In

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

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

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as Non-Network unless the Administrator, on behalf of the Employer, authorizes the continuation of care and it is Medically Necessary.

### **Urgent Care Center Services**

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

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an Emergency room at a Hospital.

See your Schedule of Benefits for benefit limitations.

### **Ambulance Services**

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

You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT),

paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

For ground ambulance, You are taken:

- From your home, the scene of 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.**

### **Diagnostic Services**

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

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease;
- Magnetic Resonance Imaging (MRI);
- CAT scans;
- Laboratory and pathology services;
- Cardiographic, encephalographic, and radioisotope tests;
- Ultrasound services;
- Allergy tests;
- Electrocardiograms (EKG);
- Electromyograms (EMG) except that surface EMG's are not Covered Services;
- Echocardiograms;
- Bone density studies;

- Positron emission tomography (PET scanning).

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

### **Surgical Services**

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

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by the Employer.

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

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Surgical treatment of morbid obesity after medical review.
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

### **Sterilization**

Regardless of Medical Necessity, you are covered for sterilization.

### **Mastectomy Notice**

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;

- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

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

## **Therapy Services**

Coverage for Therapy Services when provided as part of Physician Office Services, Inpatient Facility Services, Outpatient Services, or Home Care Services is limited to the following:

### **Physical Medicine Therapy Services**

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

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts).
- **Spinal manipulation services** to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulation whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Spinal Manipulations as specified in the Schedule of Benefits.

### **Other Therapy Services**

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents, including the cost of such agents.

- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

### **Physical Medicine and Rehabilitation Services**

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

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

**Certain Therapy Services rendered on an Inpatient or Outpatient basis are limited. See the Schedule of Benefits.**

### **Home Care Services**

Services performed by a Home Health Care Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Diagnostic Services
- Medical/Social Services
- Nutritional Guidance
- Home Health Aide Services
- Therapy Services (Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home.)
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)



- Private Duty Nursing;

**Home infusion therapy** will be paid only if you obtain prior approval from the Administrator's Home Infusion Therapy Subcontractor (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

### **Hospice Services**

Hospice care may be provided in the home or Hospice for medical, social and psychological services used as palliative treatment for patients with a terminal illness and includes routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Physician.

Covered Services include the following only when authorized by your Network Provider:

- Skilled Nursing Services (by an R.N. or L.P.N.)
- Diagnostic Services
- Physical, speech and inhalation therapies
- Medical supplies, equipment and appliances
- Counseling services (except bereavement counseling)
- Inpatient confinement at a Hospice
- Prescription Drugs obtained from the Hospice

## **Human Organ and Tissue Transplant Services**

**For cornea and kidney transplants, the transplant and tissue services benefits or requirements described below do not apply. These services are paid as Inpatient Services, Outpatient Services or Physician Office Services depending where the service is performed.**

### **Covered Transplant Procedure**

Any Medically Necessary human organ and tissue transplant as determined by the Administrator, on behalf of the Employer, including necessary acquisition costs and preparatory myeloblastic therapy.

**Covered Transplant Services** – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

### **Notification**

The Plan strongly encourages the Member to call the Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. The 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 364 days. If, within this time frame, a second Covered Transplant Procedure occurs, the Covered Transplant Benefit Period will begin one day prior to the second Covered Transplant Procedure and continue for 364 days.

### **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 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, lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation, lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Administrator when claims are filed. Contact the Administrator for detailed information.

### **Medical Supplies, Durable Medical Equipment, and Appliances**

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

Covered Services include, but are not limited to:

- **Medical and surgical supplies** - Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly. Prescription drugs and biologicals that cannot be self administered and are provided in a Physician's office, including but not limited to, Depo-Provera.
- **Durable medical equipment** - The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, oxygen equipment. Rental costs must not be more than the purchase price. Repair of medical equipment is covered. **Non-covered** items include but are not limited to air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical

supports, and corsets or other articles of clothing.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1. Replace all or part of a missing body part and its adjoining tissues; or
  2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Covered Services for prosthetic appliances include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction;
2. Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant)
3. Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act;
4. Minor devices for repair such as screws, nails, sutures and wire mesh;
5. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.;
6. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session);
7. Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract - formulae and supplies are also covered)
8. Cochlear implant;
9. Electronic speech aids in post-laryngectomy or permanently inoperative situations;
10. "Space Shoes" when used as a substitute device when all or a substantial portion of the forefoot is absent;
11. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).

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

1. Dentures, replacing teeth or structures directly supporting teeth;
2. Dental appliances;
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;

4. Artificial heart implants;
  5. Hairpieces for male pattern alopecia (baldness);
  6. Wigs (except as described above following cancer treatment);
- **Orthotic devices** – Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part . The cost of casting, molding, fittings, and adjustments are included.

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

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

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

Non-Covered Services include but are not limited to:

1. Orthopedic shoes;
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
4. Garter belts or similar devices.

### **Accident Related Dental Services**

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

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

- oral examinations;
- x-rays;
- tests and laboratory examinations;
- restorations;
- prosthetic services;
- oral surgery;
- mandibular/maxillary reconstruction;
- anesthesia.

### **Maternity Services**

Maternity Services include Inpatient Services, Outpatient Services and Physician Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn.

If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

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

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Prenatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
  1. The antepartum, intrapartum, and postpartum course of the mother and infant;
  2. The gestational stage, birth weight, and clinical condition of the infant;
  3. The demonstrated ability of the mother to care for the infant after discharge; and
  4. The availability of postdischarge follow-up to verify the condition of the infant after discharge.

- Covered Services include at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage includes, but is not limited to:
  1. Parent education;
  2. Physical assessments;
  3. Assessment of the home support system;
  4. Assistance and training in breast or bottle feeding;
  5. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

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

### **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, electroconvulsive 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.

## **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; 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.

## EXCLUSIONS

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. This list of Exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

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

1. Which are determined not Medically Necessary or do not meet the Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.
2. Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet or recognized by the Plan.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Administrator, on behalf of the Employer.
4. For services 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.
5. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's 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.
6. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
7. For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
8. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
9. For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, unless otherwise required by law or regulation. This Exclusion does not apply if You were the victim of a crime, including domestic violence.

10. For Prescription Drug Copayments or Deductibles You are responsible for under other coverage with other carriers or health plans.
11. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
12. For court ordered testing or care unless Medically Necessary and authorized by your Network Provider.
13. For which you have no legal obligation to pay in the absence of this or like coverage.
14. Prescribed, ordered, or referred by, or received from a Member of your immediate family, including your spouse, child, brother, sister, parent, or self.
15. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
16. For missed or canceled appointments.
17. For mileage costs or other travel expenses, except as authorized by the Administrator, on behalf of the Employer.
18. For which benefits are payable under Medicare Parts A, B, and/or D, or would have been payable if a Member had applied for Parts A and/or B and/or D, except, as specified elsewhere in this Benefit Booklet or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For 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. For the purposes of the calculation of benefits, if the Member has not enrolled Medicare Part D, the Plan will pay primary.
19. Charges in excess of the Maximum Allowable Amount.
20. Incurred prior to your Effective Date.
21. Incurred after the termination date of this coverage except as specified elsewhere in this Benefit Booklet.
22. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by

disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law.

23. 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.
24. For Custodial Care, Domiciliary Care or convalescent care, whether or not recommended or performed by a professional.
25. For foot care only to improve comfort or appearance including, but not limited to care for flat feet, subluxations, corns, bunions (except capsular and bone surgery), calluses, and toenails except when Medically Necessary including but not limited to, foot care for diagnosis of diabetes or for impaired circulation to the lower extremities.
26. For any treatment of teeth, gums or tooth related service except as otherwise specified as covered in this Benefit Booklet.
27. Related to weight loss or weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
28. For sex transformation surgery and related services, or the reversal thereof.
29. For marital counseling.
30. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
31. For hearing aids or examinations for prescribing or fitting them.
32. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
33. For reversal of sterilization.
34. 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.

35. For personal hygiene and convenience items.
36. For care received in an Emergency room which is not Emergency Care, except as specified in this Benefit Booklet.
37. For expenses incurred at a health spa or similar facility.
38. For self-help training and other forms of non-medical self care, except as otherwise provided herein.
39. For examinations relating to research screenings.
40. For stand-by charges of a Physician.
41. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.
42. Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy.
43. Related to any mechanical equipment, device, or organ.
44. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility.
45. For Private Duty Nursing Services except when provided through the Home Care Services benefit.
46. Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.
47. Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergiel synchronization technique (BEST) and iridology-study of the iris.
49. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
50. Treatment of telangiectatic dermal veins (spider veins) by any method.
51. Drugs in quantities which exceed the limits established by the Plan.
52. For elective abortions.
53. For Prescription Legend Drugs or Mail Service drugs.
54. For developmental delays, autistic disease, learning disabilities and mental retardation.
55. 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.
56. For residential treatment services. Residential treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
57. For supervised living or half-way houses.
58. For room and board charges unless the treatment provided meets the Administrator's Medical Necessity criteria for Inpatient admission for your condition.

## **CLAIMS PAYMENT**

### **How to Obtain Benefits**

When your care is rendered by a Network Provider you are not required to file a claim. Therefore, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply, unless the claim was not filed by the Provider.

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim use a claim form.

### **Maximum Allowed Amount**

#### **General**

This section describes how the Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Non-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 the Plan will allow for services and supplies:

- that meet the Plan’s definition of Covered Services, to the extent such services and supplies are covered under your 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 Benefit Booklet.

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

When You receive Covered Services from a Provider, the Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the Administrator's determination of the Maximum Allowed Amount. The Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the 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 a Non-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with the 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 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](http://www.anthem.com).

Providers who have not signed any contract with the Administrator and are not in any of the Administrator's networks are Non-Network Providers.



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

1. An amount based on the Administrator's Out-of-Network Provider fee schedule/rate, which the Administrator has established in its' discretion, and which the 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 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 the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services, unadjusted for geographic locality, for the same services or supplies. Such reimbursement amounts will be updated 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 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 Administrator are also considered Non-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 Administrator and that Provider specifies a different amount.

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

Customer Service is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Network Provider. In order for the 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.

### **Member Cost Share**

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

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Non-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on your benefits when using Non-Network Providers. Please see the Schedule of Benefits in this 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 Non Network Provider. Both services specifically excluded by the terms of your Plan and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, your Lifetime Maximum, benefit caps or day/visit limits.

In some instances You may only be asked to pay the lower Network cost sharing amount when You use a Non-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from a Non-Network Provider such as a radiologist, anesthesiologist or pathologist who is not employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However, You also may be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge.

### **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 a Non-Network Provider. In such circumstance, You must contact the 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 a Non-Network Provider and are not able to contact the Administrator until after the Covered Service is rendered. If the Plan authorizes a Covered Service so that You are responsible for the Network cost share amounts, You may still be liable for the difference between the Maximum Allowed Amount and the Non-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 Allowable Amount. **If services are performed by Non Network Providers**, then you are responsible for any amounts charged in excess of the Plan's Maximum Allowable Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact the Administrator for more information.

### **Continuous Coverage**

If you were previously covered by a Plan with the Employer and with the Administrator with no break in coverage, you will receive credit for any accrued Deductibles and Out-of-Pocket amounts. However, any maximums used under that Plan will be carried over and charged against the maximums of the Plan.

### **Payment of Benefits**

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 Administrator, on behalf of the Employer, will not honor a request to withhold payment of the claims submitted.

**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.

**Notice of Claim**

The Plan is not liable, unless the Administrator, on behalf of the Employer, receives written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given. The notice must be given to the Administrator within 24 months of receiving the Covered Services, and must have the data the Administrator needs to determine benefits. If the notice submitted does not include sufficient data the Administrator needs to process the claim, then the necessary data must be submitted to the Administrator within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If the Administrator has not received the information it needs to process a claim, the Administrator will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, the Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator generally will make its request for additional information within 30 days of the Administrator's initial receipt of the claim and will complete its processing of the claim within 15 days after the Administrator's receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

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

## **Claim Forms**

Many Providers will file for you. If the forms are not available, either send a written request for claim forms to the Administrator or the Employer, or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to the Administrator, on behalf of the Employer, without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

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

## **Time Benefits Payable**

The Plan will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If the Administrator has not received the information needed to process a claim, the Administrator, on behalf of the Employer, will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, the Administrator cannot complete the processing of the claim until the additional information requested has been received. The Administrator, on behalf of the Employer, generally will make a request for additional information within 30 days of the Administrator's or Employer's initial receipt of the claim and will complete processing of the claim within 15 days after the Administrator's receipt of all requested information.

At the Employer's discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, The Plan may reimburse those other parties and be fully discharged from that portion of its liability.

## **Member's Cooperation**

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

## **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 balance 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 Administrator, on behalf of the Employer, to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any).
- General information about your Appeals rights and for ERISA plans, information regarding the right to bring 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](http://www.anthem.com) for more information about such arrangements.



## **GENERAL PROVISIONS**

### **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 Administrator and the Employer and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Administrator by the Employer, and any and all statements made to the Employer by the 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 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.

### **Disagreement with Recommended Treatment**

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Administrator, Employer, nor any Provider shall have any further responsibility to pay benefits or provide care for the condition under treatment or any complications thereof.

## **Circumstances Beyond the Control of the Plan**

The Administrator, on behalf of the Employer, 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 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 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 Administrator, on behalf of the Employer, shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Administrator and Network Providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the 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 an 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 the back of your Identification Card.

## **Coordination of Benefits**

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 (*carve-out*) Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

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

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

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

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

The following are non Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
6. The amount that is subject to the Primary high-deductible health plan's deductible, if the Claims Administrator has been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
7. 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.

### **Medicare**

Any benefits covered under both this Plan and Medicare will be paid pursuant to Medicare Secondary Payer legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Plan provisions, and federal law.



Except when federal law requires the Plan to be the primary payer, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, we will calculate benefits as if they had enrolled. For the purposes of the calculation of benefits, if the Member has not enrolled Medicare Part D, the Plan will pay Primary.

### **Worker's Compensation**

The benefits under the Plan are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's 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 Worker's Compensation.

### **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.

### **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, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

#### **Subrogation**

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your 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:

**The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or  
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.

### **Community Insurance Companies**

The Employer, on behalf of itself and its participants, 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 Companies (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association 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**

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 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.

### **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 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 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.

## **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 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**

Anthem 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 Complaints and 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. Anthem'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 Allowable Amount. A Member may utilize all applicable Complaint and Appeals procedures.

## **Payment Innovation Programs**

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

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

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

## YOUR RIGHT TO APPEAL

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 Customer Service by calling the number on the back of Your ID card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of your complaint, You have the right to file an Appeal, which is defined as follows:

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

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

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

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

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

### **Notice of Adverse Benefit Determination**

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

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

- information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Claims Administrator may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

## **Appeals**

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

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

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

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

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

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

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and



copies of, all documents, records, and other information relevant to your claim. “Relevant” means that the document, record, or other information:

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

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

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

### **How Your Appeal will be Decided**

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

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

### **Notification of the Outcome of the Appeal**

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

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

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

### **Appeal Denial**

If your appeal is denied, that denial will be considered an adverse benefit determination. The

notification from the Claims Administrator will include all of the information set forth in the above section entitled “Notice of Adverse Benefit Determination.”

### **Voluntary Second Level Appeals**

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

### **External Review**

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

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

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

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

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

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

Anthem Blue Cross and Blue Shield, ATTN: Appeals, P.O. Box 105568, Atlanta, Georgia 30348  
This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to

any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

**Requirement to file an Appeal before filing a lawsuit**

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

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

## **HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW**

### **Grandfathered Health Plan**

This Plan believes this coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator or your Employer.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

### **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 pre-certification. For information on pre-certification, 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).

### **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, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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 "30 days" or any longer period that applies under the plan 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.

### **Mental Health Parity and Addiction Equity Act**

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